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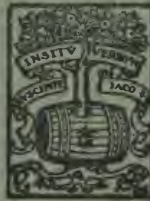
The Journal of Cutaneous Diseases

INCLUDING SYPHILIS

Under the Editorial Direction of

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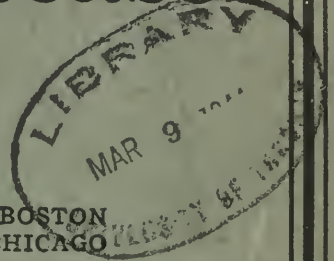
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THE JOURNAL OF CUTANEOUS DISEASES

INCLUDING SYPHILIS

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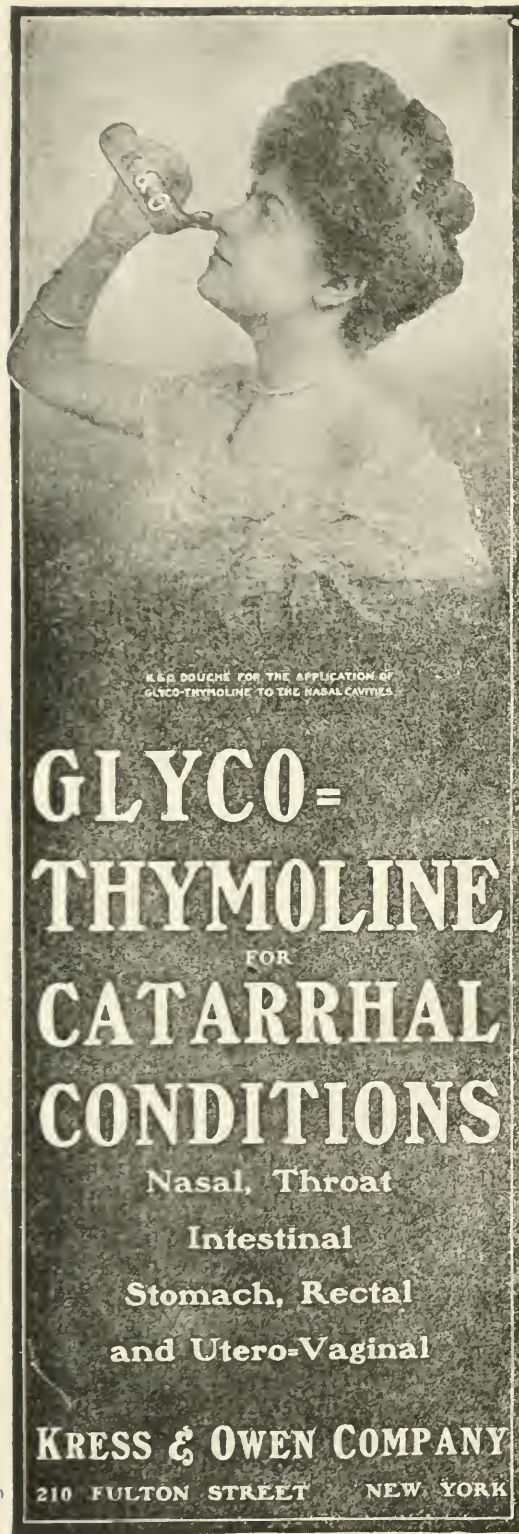
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THE JOURNAL OF CUTANEOUS DISEASES

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NO. 3

TUBERCULIDES IN RELATION TO GENERAL TUBERCULOSIS.

By A. RAVOGLI, M. D.

TUBERCULOSES of the skin are usually considered as local diseases. In some cases, however, they assume a generalized appearance, invading large areas of the cutaneous surface. In the local manifestations of tuberculosis of the skin we usually see infiltrations, ulcerations, proliferations, destruction, while in tuberculides we recognize superficial lesions, which can heal up of themselves. To explain the mild character of these tubercular affections the authors have resorted to an attenuated type of the disease, as products of the Koch bacillus. This has not been applied to the cases of the skin alone, but also to some affections of the internal organs, which had formerly been considered of an obscure nature. As a consequence some pleurites, polyadenites, splenic hypertrophies, arthritides have been recognized as of an attenuated tubercular nature.

For the skin, lupus erythematosus, a clinically tubercular affection, as for a long time Besnier maintained, offers different clinical aspects, which have caused many authors to doubt its tubercular origin. Yet from the observations of Boeck, of Roth and our own we believe ourselves right in considering it a tubercular disease of the skin of an erythematous type.

Hallopeau¹ on a pathogenic base divided the tuberculoses of the skin into four groups. In the first he comprehended those affections of bacillary nature, such as lupus vulgaris; in the second, some eruptions of a milder type which he considered as due to a modified or attenuated bacillus, as lupus erythematosus. In the third he placed some eruptions, non-bacillary, but only the result of toxines, produced by bacilli existing in the internal organs, such

Read at the 32d Annual Meeting of the American Dermatological Association, Annapolis, Maryland, September 24, 1908.

as lichen scrofulosorum, acne cachecticorum, erythema due to tuberculin. The last class was given up to those skin eruptions which affect tubercular individuals such as the tubercular eczema of Hutchinson, Unna and Neisser.

The studies of Hallopeau, although of great clinical importance, were, nevertheless, based on a hypothesis and had no pathological support. This important subject was taken up again by Darier² in his communication "les tuberculides cutaneés." Under this head he grouped many cutaneous eruptions, which were scattered in different chapters, of an obscure origin as acne cachecticorum, acne scrofulosorum, lupus erythematosus disseminatus. (Boeck.)

The tuberculides have some peculiarities in their symptoms, which, without much difficulty, can be recognized. The eruptions consist of lesions of long standing, obstinate, appearing in successive crops. The dominant form is the papule or the intradermal nodule, this is usually indolent. Gradually it forms a pustule, which, break down and forms a crust. Under the crust is an ulcerated surface, which, after healing up, leaves a cicatricial pigmented spot. In some cases these eruptions are on persons without apparent symptoms of tuberculosis, but in most of the cases they are associated with tuberculosis of the lungs, of the lymphatic glands, of the joints or else with tuberculosis of the skin.

In the lesions of the skin the presence of the bacillus has not yet been demonstrated. The process consists of an infiltration around the follicles of small mononuclear leucocytes, which gradually die and the mass of the infiltration is converted into necrotic substance. If the Koch bacillus has not yet been seen in these lesions, we must see, as Pautrier³ says, their clinical relation to the general or local tuberculosis.

The meaning of the tuberculide is not to be restricted to papular or acne-form eruptions, but as leprides and syphilides, is to comprehend all eruptions of erythematous, papular, nodular, vesicular character, which are the products of tuberculosis.

The idea of Hallopeau and the correctness of his views, namely, that some of the tuberculides may be the result of toxins from the tubercle bacillus, added the class of the toxi-tuberculides.

Leredde⁴ limited the tuberculides to lupus erythematosus, acnitis, folliculitis and angiokeratoma (Mibelli), for the simple reason that these affections have not, so far, shown the presence of tubercle bacillus. He refers to them also as lupus erythemato-tubercular, which shows nodules at the edges, and considers it a transitional

form between lupus erythematosus (Cazenave) and lupus vulgaris (Willan).

The symmetrical disposition of the tuberculides, so much insisted upon by Boeck⁵, cannot be considered of so great an interest, when we see lupus erythematosus, erythema induratum and other typical tuberculides limited to one side. Nor can his views of the bacterial toxines acting upon the vasomotor centers be consistently maintained, because it presupposes the toxic origin of the eruption and a toxic action on the vasomotor system. But Boeck pointed out the pathological lesions of the tissues in the tuberculides, and he showed that they apparently start from the blood vessels. According to his views the tubercle bacilli, finding their way into the circulation, may stop at some ramifications of the last cutaneous vessels, and produce lesions which would be of toxic-tubercular origin.

In the opinion of Darier tuberculides stand in relation to tuberculosis, because they are found in individuals affected with tuberculosis. He rejects the idea of the toxines causing the tuberculides, but on the other hand tubercle bacillus has not been found in them.

The only points of relation of the tuberculides to tuberculosis is their co-existence and their successive appearance in patients affected with tubercular disease, or in whom tuberculosis is suspected. In lichen scrofulosorum, acnitis, lupus disseminatus, a true tubercular infiltration exist, with giant cells, epithelioid cells and plasma cells grouped in nodules, and a tendency of the mass to caseous degeneration. In lupus erythematosus and folliculitis there is an infiltration composed only of small lymphocytes around the blood vessels and also some plasma cells. The pathological alterations are mostly on the blood vessels, which are usually enlarged, but later on their caliber diminishes, causing lack of nutrition of the cells and in consequence a necrosis of the focus.

We do not find any objection to the tuberculides, as a family of diseases of the skin dependent upon general tuberculosis, and indeed, we admit that all eruptions disseminated on the body and of tubercular origin are tuberculides. Vice versa all deep tubercular foci, limited, circumscribed, with a tendency to ulceration and proliferation must be considered tuberculosis.

In the tuberculides the process spreads, the tubercle bacillus is carried into many parts of the body by the circulation, as occurs in lichen scrofulosorum, in papulo-necrotic acne (acne cachecticorum) in some cases of tuberculosis verrucosa diffusa. In other cases the process is more of a toxic or toxi-bacillary origin, as in lupus ery-

thematosus diffusus, in tubercular erythema, in erythema induratum.

Indeed, the principal types of the tuberculides are erythematous and nodular, both characterized by infiltration, which ends in a sclerotic, cicatricial atrophic patch. These dermatoses are found in individuals affected with tuberculosis of the lungs, of the glands, of the joints or of the bones. In some cases internal tubercular affections are not manifest, but following them in life tubercular symptoms will develop. In some cases hereditary tubercular antecedents in the family are apparent, and during their life-time is found a tubercular environment.

The first group of tuberculides is well represented by Fig. I, follicular tuberculide, which is only a variety of lichen scrofulosorum and of acne cachecticorum. The patient, a colored man, 31 years old, rather well built, whose father is still living, but whose mother died with consumption, has enjoyed good health with the exception of an obstinate eruption of the face. He was admitted to the City Hospital and on account of the eruption was assigned under our service. When the patient was received, he was rather weak, feverish and annoyed by an obstinate dry cough with scanty expectoration. No syphilitic history nor syphilitic stigmata could be found. He had suffered hæmorrhages from the lungs.

At the inspection he showed superclavicular triangles abnormally deep as were also the subclavicular regions. Percussion revealed an area of marked dullness in both suprascapular triangles. The auscultation found dry sub-crepitant rales in the left suprascapular triangle. The expectoration was examined for bacilli with positive result.

Eruption—an acne eruption had constantly been found on his face and chest for several years, which is well shown by the skin, pitted with innumerable cicatrices. "Last year" *i. e.*, 1907, a papulo-pustular eruption invaded the neck, the back, the shoulders, the lumbar region, the chest, a few pustules were scattered on the abdomen, and the arms were entirely covered by the eruption.

The eruptions consisted of nodules having in the center a hair follicle, red-brownish in color, of the size of a split pea, many coalescing together formed large patches, hard and resistant. The nodules, after remaining for sometime, began to undergo a necrotic process as is clearly shown in the illustration. They were covered with hard, thick, dry, whitish crusts, very strongly adherent, which on falling off left a superficial scar surrounded by a deep red-brownish pigmentation.

PLATE XVIII—To Illustrate Article by Dr. A. Ravogli.

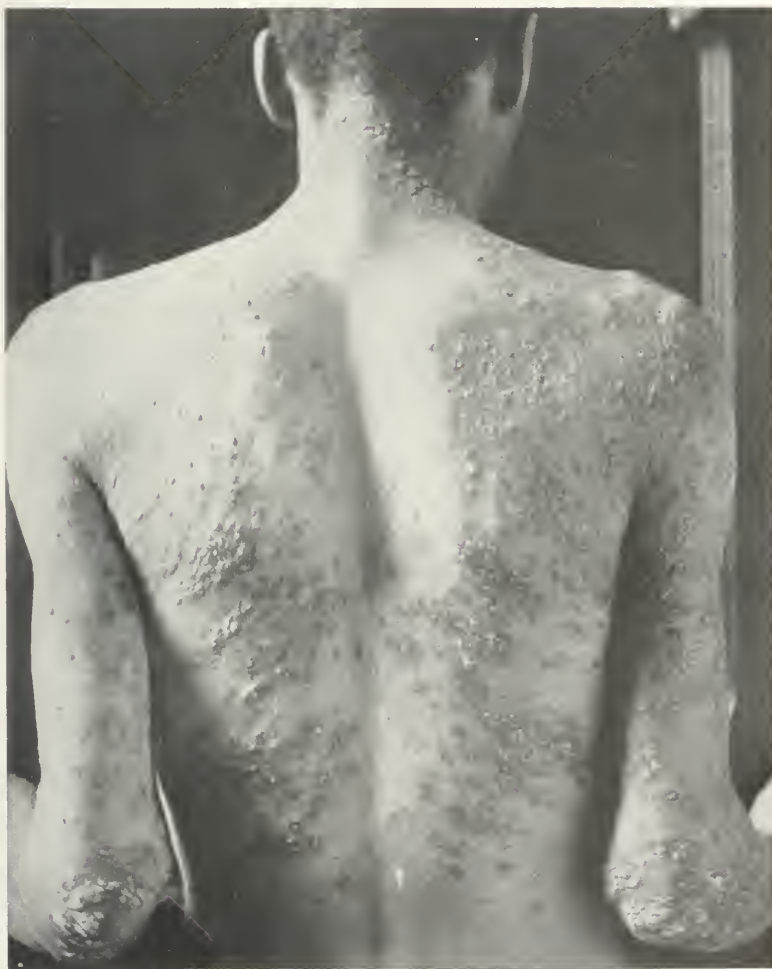


FIG. 1.

PLATE XIX To Illustrate Article by Dr. A. Ravogli.



FIG. 2.

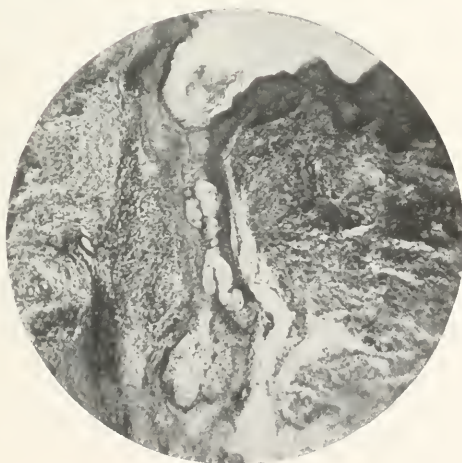


FIG. 3.

The patient was treated with cod-liver oil internally and externally, the improvement was remarkable, and after six weeks he asked for his discharge. A piece of the affected skin was taken for biopsy, in order to establish the exact nature of the lesions. The specimen, after hardening, was mounted in celloidin, and then cut in sections and stained in hæmatoxylin by my assistant, Dr. George H. Werk.

The microphotograph shows that the process involves the hair follicle and the tissues surrounding it, so much so that the affection is a follicular and perifollicular one. The infundibulum of the follicle and the connective tissues are a mass of infiltration of small leucocytes, and amongst them the giant cells are conspicuous. The mass of fat of the sebaceous glands is greatly increased, showing a compression and retention. The blood vessels are congested, and the infiltration is prominent around them, which would show that the process is greatly connected with the condition of the tunics of the vessels. It may be that the tubercle bacillus itself or the toxins are carried in circulation through the vascular ramifications to the follicles of the hair and to the glands, where they produce the inflammatory process with their irritating presence. In a short time there is the whole syndrome which is seen in the tubercular nodules, the lack of nutrition of the infiltrating cells, their decay, their degeneration, followed by re-absorption, or by necrosis, resulting in a scar or superficial atrophic cicatrix. The scars of the tuberculides are so characteristic, that Hallopeau and Besnier claim to be able to establish a diagnosis of tuberculides from the remaining scars. The abundant pigmentation which remains around the scars for a long time is witness of an effusion of coloring matter of the blood in the tissues of the derma. For these reasons we would be inclined to support the idea that the origin of typical tuberculides of all kinds is from the blood vessels, and consequently of hæmatogenic nature.

II. In our hospital service there was also referred to us a colored boy, six years old, who was covered with lichen scrofulosorum. The boy was admitted in the orthopædic department on account of tubercular arthritis of the left elbow. The eruption consisted of small papules, yellow-brownish in color, which were covered with greasy crusts. In some places the papules were coalescing in patches, in others they were scattered. The eruption covered the whole trunk and a portion of the upper extremities. An injection with one-hundredth of a milligram of tuberculin, brought a marked reaction.

The treatment was cod-liver oil internally and externally with satisfactory results. In both cases the eruptions were typical tuberculides of a nodular type, which were in strict relation with the general tubercular condition of the patient.

Lupus erythematosus can be considered as the erythematos group of tuberculides. In the question of lupus erythematosus we believe it necessary to draw a line between the circumscribed or discoid, and the diffused form.

Lupus erythematosus discoideus which frequently occurs, slowly invades the face, remains for years and as a result, leaves atrophic cicatricial patches, must be considered more as a form of superficial, local cutaneous tuberculosis. The second variety, lupus erythematosus diffusus, must be regarded as a true tuberculide of the erythematos kind, and is connected with general tuberculosis. Indeed, lupus erythematosus diffusus has a quick and stormy process, its point of origin is the blood vessels, as shown by the hæmorrhages. In our experience all cases of lupus erythematosus diffusus had a fatal ending, some by tuberculosis of the lungs, some by tuberculosis miliaris acuta, one by tuberculosis of the intestines and of the peritoneum. By drawing this line of demarcation we shall have explained the statement of Campana, that lupus erythematosus does not always react to the tuberculin test. In tuberculosis verrucosa cutis extending nearly to the whole left leg in a strong, healthy man without general tubercular symptoms, the opthalgo-tuberculin test was repeatedly applied, always with negative results.

It seems that the tissues of the skin through the thick structure of the derma, protect the organism from the progress of the tubercle bacillus, which is maintained encapsuled in the thick plasmom which is formed around the tubercular foci.

The distinction of tuberculides as typical and atypical as advocated by Pautrier, Schidachi and others is a very useful one. It is not necessary to group with the tuberculides which are the eruptions from general tuberculosis, certain eruptions which are found in individuals, who may have a predisposition to tuberculosis. Acnitis, folliclitis, angiokeratoma, are related to tuberculosis only on account of being found in individuals predisposed to tuberculosis, but they are not a general tubercular expression.

The typical tuberculides form a natural group represented by erythematos diffused patches of brown-violaceous color or by papular eruptions of different degree. The case of follicular tuberculide, which we have reported is an illustration of the papulo-necrotic

group and it can be placed between lichen scrofulosorum and acne cachecticorum. A study of these forms of eruption clearly shows, that from tuberculide to tuberculide, and from tuberculide to tuberculosis there are transitional forms, which mark the different shades.

It happens that tuberculides of a different type are found together in the same patient, as Jadassohn⁶ demonstrated, in the case where lupus vulgaris of the face was present with lupus pernio of the fingers and toes, and in another, when together with acne exanthem, and folliculitis, there was an extensive lupus erythematosus. This proves much more conclusively that the tuberculides are originated by general tuberculosis. Between tuberculosis of the skin and tuberculides there is a great difference, as cutaneous tuberculosis is local and only with difficulty can the tubercle bacillus extend its infectious action to the general system, while the tuberculides are the result of a general tubercular infection.

The presence of tuberculides does not increase the severity of the general tubercular infection, but shows that the infection is of a severe nature. We find that the cases referred to by Carl Cohn⁷ and Marie Opificius⁷ under the name of lupus follicularis disseminatus, and those of erythema induratum reported and so well studied by Tomimatsu Schidachi⁸ confirm our views in reference to the relation of the typical tuberculides to general tuberculosis.

In some cases tuberculides, especially of the type of erythema induratum, may produce ulcerations, as was observed by Hutchinson, Sommerville, Hirsh, Schidachi, and ourselves in two cases. The ulcerations have all the characters of the tubercular ulcers, brownish-red, honey-combed appearance, no tendency to heal up. These, however, are not to be grouped with miliary tubercular ulcers (Kaposi), which are found around the anus or the mouth of patients in an advanced stage of tuberculosis. They belong to the true tubercloses and are the result of the direct inoculation of the tubercle bacilli which are present in the excretive substances passing through the orifices.

Tuberculides do not spare the mucous membranes. Hirsh, Schidachi and Bodin have described superficial ulcerations of the mouth accompanying other tubercular affections.

In two cases of lupus erythematosus diffusus we have seen in one the palate covered with bluish erythematous spots, and in the other the same spots of different size, extended to the mucous membrane of the cheeks and of the tongue. Both were women and died with general tuberculosis in a short time.

As a conclusion from the considerations of the tuberculides we find that typical tuberculides have to be separated from atypical tuberculides. Typical tuberculides are of the erythematous and papulo-necrotic type, generalized affecting large surfaces of the body. They are the expression of general tuberculosis, but they bear no influence on the general disease.

¹ Hallopeau H. Rapports de la tuberculose avec les maladies de la peau, autres que le lupus. J. D. C., London, 1896.

² Darier J. Les Tuberculides cutanées. J. D. C., Paris, 1900.

³ Pantrier L. Les Tubercules cutanées atypiques. *Tuberculides*. Paris, 1903.

⁴ Leredde, Les Tuberculides. *Semaine médicale*. Janvier, 1900.

⁵ Boeck, C. Die exantheme der Tuberculose. *Archiv. f. Dermat und Syph.*, 1898. C. XLII.

⁶ Jadassohn, Demonstrationen zur Tuberculid Frage. *Monatsh. f. Prakt. Dermat.* B. 45, p. 424.

⁷ Cohn und Opificius. Lupus follicularis disseminatus. *Arch. f. Derm. und Syph.* Bd. 90, p. 339

⁸ Tomimatsu Schidachi. Über das Erythema induratum. *Arch. f. Derm. und Syph.* Bd. 90, p. 371.

ECZEMA OF THE TOES.

By E. WOOD RUGGLES, A.M., M.D., Rochester, N. Y.

ECZEMA of the toes, judging from its infrequent or cursory mention in both text-books and articles on dermatology, is either a rare or a very unimportant affection. Duhring and several other authors do not mention it at all and the majority of those who do so merely speak of its existence in connection with eczema of the soles of the feet, whereas in reality it generally occurs independently of eczema of any other region or at all events of any contiguous area.

Pye Smith (*Diseases of the Skin*, London, 1893) also calls attention to this feature as follows: "It is rarely associated with the disease in other localities and must be treated entirely by topical remedies."

Hyde, in the volume on *Skin Diseases of the "Twentieth Century Practice of Medicine"* states: "Eczema of the feet is most common about the toes and the interdigital spaces, spreading thence over the instep." His experience in this respect is certainly very exceptional for I have had a good many cases of eczema of the feet and very few of eczema of the toes and have never yet seen a case where it extended from the toes upon any other part of the feet.

The only description of the condition which is at all complete or accurate is that given by Jamieson (*Disease of the Skin*, London, 1892): "Besides these, there is a very annoying form of eczema which occurs between the toes, more particularly the three outer. At first there is little more than itchiness, which comes on after the out-of-door boots or shoes are taken off at night, or less frequently in the morning. It does not give rise to much trouble in the day-time. Those subject to it have, in my experience, been between the ages of forty and fifty and active and cleanly. If allowed to increase, the epidermis peels off in the spaces between the toes and fissures are apt to form. It tends to recur after being removed by treatment or having, for the time, subsided spontaneously."

Read at the 32d Annual Meeting of the American Dermatological Association, Annapolis, Maryland, September 25, 1908.

Etiology

As regards its etiology there are several factors which seem to act as predisposing causes. In all of my cases the patients have been brain-workers; one clergyman, one physician, one clothing manufacturer and several students. This is rather remarkable as, at first thought, one would await its frequent occurrence among the laboring classes, whose habits regarding cleanliness are not of the best, whose socks are coarse, ill-fitting and poorly dyed, their boots or shoes stiff, improperly made and often leaky and whose vocations frequently contribute additional filth to feet which are seldom bathed.

Patent leather shoes which cause maceration of the skin by confining the perspiration, thus giving the effect of a poultice, do, however, act as a contributory cause.

Habitually cold feet, especially those which become clammy while their possessor is engaged in mental toil, are also subject to this affection. In two of my cases this has been a prominent feature.

Millions of mortals, however, present these predisposing causes yet few acquire eczema of the toes. Why is there this apparent inconsistency? The subject has interested me a great deal and I believe I have at last hit upon the proper explanation of at least most of the cases. This explanation is that the chief cause resides in the presence of a broken-down transverse arch of the foot.

Very few realize, unless their attention has been called to it, that there is a second arch of the foot, which is as essential an anatomical feature of the perfect foot as is the longitudinal or plantar arch. This is located at the distal extremities of the metatarsal bones and its integrity is maintained by the transverse metatarsal ligament which passes inferiorly across the anterior extremities of all the metatarsi.

The penalties attending its obliteration are not so severe, however, as in flat-foot and the patient is not so frequently forced by acute or chronic discomfort to consult the orthopædist or general practitioner. Therefore the importance of a perfect transverse as well as plantar arch escapes detection and the condition, even if noticed, is dismissed as of no practical moment.

A painful affection of the toes, first described by Morton and called after him Morton's Neuralgia, is caused by this condition and the pain is often so intense that the patient, wherever he is, even if upon the street, is forced to stop, remove the shoe and manipu-

late the joints, until he has restored the metatarsal bones to their normal position.

This weakness or absence of the transverse arch may be merely part of a general breaking down of all the ligamentous structures of the foot, thus being associated with flat-foot. In other cases it co-exists with a normal plantar arch. Badly shaped shoes have much to do with its causation.

Now if one exerts upward pressure upon the sole of a normal foot or if he preserves the transverse arch in a weakened foot by lateral pressure and makes the same upward pressure, he will observe that the toes are in contact along their inferior borders only. If now the lateral compression be increased, as if by a narrow shoe, the toes still are not brought into intimate contact except along their lower borders.

If the same upward pressure is brought to bear upon a broken-down transverse arch, or if the person is made to bear his weight upon the foot, the toes, especially the outer three, are very closely approximated throughout their contiguous surfaces and if lateral compression is applied in addition, as would be accomplished by a narrow shoe, they are pressed very tightly together. This is not the case in reference to the first interdigital space, since the great and the second toe are separated by an appreciable distance, an eighth of an inch or more. This fact accounts for the rare involvement of this space.

This intimate contact acts in two ways to bring about a lowered vitality in the skin thus compressed. In the first place sweating is produced which leads to maceration and subsequent shedding of the epidermis. Secondly, the branches of the musculo-cutaneous nerves are compressed and the nervous and vascular supply of the skin is interfered with.

There is one fact which seems to combat this theory, namely, that probably a sixth of all adults have a more or less weakened transverse arch, while a very small number have eczema of the toes. Yet this same contradiction attends all the etiologic factors of eczema. Five persons may pursue an occupation which requires the more or less constant exposure of the skin to various irritants and escape injury indefinitely, while the sixth may not be able to endure it a single week without acquiring eczema.

While studying with Brocq at Paris a laundress came to the dispensary with a violent eczema of the hands and forearms. She had followed this occupation for fourteen years with no bad re-

sults whatever. About three weeks previously she had suffered a severe mental shock by being suddenly told that her husband had been killed. The report proved to be false but ten days later this eczema appeared and grew steadily worse in spite of all treatment so that eventually she was forced to give up laundry work altogether.

The evident explanation is that the shock to the nervous system had brought about a permanent lowered vitality of the tissues so that the skin was no longer able to endure the irritant action of prolonged immersion in soapy water. It may be that the nervous element mentioned as existing in all my cases, rendered the skin of the toes unable to withstand the conditions produced by their weakened transverse arches.

Symptomatology.

As a rule the condition is slow in development. For months or years the patient, if observant, will notice that the contiguous surfaces of the third, fourth, and fifth toes, less often the second, very rarely the great toe, periodically peel. Slight irritation is generally present. New, sound epidermis will then form and this in its turn be desquamated. Later the peeling process becomes more frequent and profuse and a considerable area of macerated skin, bleached and sodden, will be shed at one time, leaving a tender, violaceous dermis exposed.

At this time a moderate itching, not severe enough to be very troublesome, begins, transient at first, occurring chiefly on donning and doffing the foot-wear. Later this pruritus tends to become more or less constant but very rarely does it approach in intensity that of eczema of other areas.

Fissures, often quite painful, form, especially in the furrow between the fourth and fifth toes and may extend to the lower surface. If the individual is not cleanly the natural odor of the feet is increased.

Then, without apparent cause, even in midsummer when perspiration is most profuse, the eczema will clear up and the skin become apparently normal, only, however, to again start up the same process after a shorter or longer period of quiescence. Naturally this transient recovery is more apt to occur in winter when perspiration and its attendant maceration are less in evidence. Some of the cases, however, are never entirely free.

The process rarely attains anything like the severity of eczema

in other parts of the body, largely, I believe, because the toes are less irritated by scratching, they being encased in a fairly rigid covering two-thirds of the twenty-four hours and not within easy reach by the fingers, even when in bed.

A peculiar sensation which is generally described as "half itching, half smarting," noticed only on disrobing at night and on rising in the morning, is premonitory of a fresh attack and when it is felt, treatment should be instituted at once.

These cases bear a certain resemblance to four cases described by Dubreuilh as "Eczema hyperkeratosique" (*Annales de Dermatologie et Syphilis*, Dec., 1889). The following is an abstract of his paper: "The surfaces of the interdigital spaces in the affected toes, increasing in intensity from the second to the last space, are covered by a thick, cornified layer of tenacious, blueish-white epidermis, sometimes a millimeter in thickness, which is opaque, pliable and resistant. This epidermis keeps detaching itself in scales, up to a centimeter in length, which, however, are very adherent at one border, so that their attempted removal causes considerable pain. Between them, and seen through a fissure at the bottom of the interdigital fold, is a violet-red dermis covered by a thin, transparent epidermis, which promptly becomes white and opaque, even before the preceding scale has detached itself. This process reproduces itself incessantly, yet without much pain or pruritus. The scales resemble moistened parchment and seem like macerated epidermis, although hyperidrosis is not present and in one case the lesions existed in the hands as well as the feet. Some of the cases presented scaly eczema in other localities. In all these cases the condition had existed several years before first seen and proved very rebellious to treatment."

Treatment.

The first essential is cleanliness, the next measures which will avoid perspiration, such as the wearing of cotton foot-wear and of properly constructed shoes, made of non-glazed leather. These should be of the so-called orthopædic shape, abundantly wide so as not to compress the toes together and possessing a transverse arch to maintain them in their normal position.

The local treatment which has produced the best results consists in bathing the feet once or twice daily in cold water, drying them and then applying with a camel's-hair brush a ten per cent. solution of tannic acid and two per cent. of salicylic acid in alcohol. This preparation also acts very effectively as a prophylactic, when

the peculiar pruritus above referred to gives warning of a fresh attack.

For severer cases and especially for those in which enough fissuring exists to render this lotion quite painful, tar ointments, *c. g.*, ten to twenty per cent. of ung. picis liquidæ with zinc oxide and cold cream are preferable, to be followed by the lotion when the condition is sufficiently improved.

I have made notes which are complete in six of these cases:

Case 1. W. R., clergyman, fifty years of age when first seen five years ago. Heredity and general health good except that several years ago he was obliged to give up his pastorate for a year on account of an attack of neurasthenia, diagnosed as of the lithæmic variety. He has always been afflicted by extremely cold, clammy feet when engaged in mental work, *c. g.*, when writing his sermons and habitually wears very warm slippers and has a thick rug under his feet when thus occupied. As long as he can remember there has been "occasional peeling of the toes, without itching and not leading to raw flesh." The more aggravated condition began shortly before he consulted me.

At that time the epidermis of the second, third, and fourth interdigital spaces of both feet was macerated and partially peeled away, leaving a dermis which was tender, inflamed and violaceous in color, with several fissures at the interdigital furrows and at the base of each little toe on the plantar surface. These fissures were quite painful, while pruritus was only of moderate severity, occurring principally on rising and on removing the socks at night. This patient had a pronounced case of flat-foot, both the plantar and transverse arches being completely broken down.

The ointment above mentioned acted very favorably in this case, reducing his discomfort to a minimum. He wrote me recently, "I can hardly say that I am ever entirely rid of it, but there are intervals—it may be of several weeks—when it is scarcely discernible."

Case 2. A. L., Hebrew, fifty-seven years of age, manufacturer of clothing. Heredity and general health good. Has suffered from eczema of the toes for about fifteen years, but of one foot only. The symptoms and characteristics were the same as in the preceding case except that the inflammation was much more severe, sometimes making him really lame. The peculiar feature of this case was that the right foot, which was the one affected, presented a badly broken-down transverse arch, while the left foot was nor-

mal. This goes to sustain my theory that the chief causes lies in the absence of a normal arch.

Case 3. W. E., physician, forty-seven years old. Heredity good, general health fair, except that he is a neurasthenic of the lithæmic type. Has suffered from eczema and though not coincidently with that of the toes. Has winter eczema of the palms. Never had any trouble with the feet until five years ago last summer, when he spent a month on a fishing trip in Canada. During this time he wore constantly moccasins and thick, woolen, lumberman's socks. The feet were continuously bathed in perspiration and frequently water-soaked as well. Soon after his return he noticed a slight irritation between the toes, followed later by maceration and peeling of the epidermis. Later there occurred a more severe form of eczema, the exposed dermis being inflamed and violaceous and fissures appeared frequently. Since the onset, at very irregular intervals, have occurred periods, sometimes of months, during which the skin appeared absolutely normal, followed by recurrences, often in winter and without any ascertainable cause. This patient possesses splendidly developed plantar arches and a really aristocratic instep, but the transverse arches are totally lacking.

For nearly a year, since using the tannin and salicylic acid lotion he has been practically free of the disease. He is, however, careful to apply it for several days at the first premonition of a fresh attack, as evidenced by the peculiar smarting itch heretofore alluded to.

Cases 4, 5 and 6 occurred in comparatively young men, students in the Rochester Theological Seminary. The course and symptoms were similar to those in the first three cases. One of them presented marked hyperidrosis of the feet. The only other feature worthy of mention is the occurrence of three cases of this quite rare affection during two years in an institution which numbers only about ninety students.

XANTHOMA MULTIPLEX.

BY JAMES MACFARLANE WINFIELD, M. D.

Professor of Diseases of the Skin, and Alfred Potter, M. D.
Instructor in Diseases of the Skin, at the Long Island College Hos-
pital, Brooklyn, N. Y.

TR., female, aged four years; born in America of Russian Hebrew parents. Family history negative; grand-
• parents living and well; the father is thirty-eight years old and has always been healthy; the mother is thirty-seven years of age; she has had seven living children, four girls and three boys, one still-born child and two miscarriages; there are no signs of syphilis in either parent; we were unable to obtain any history of xanthoma in any of the ancestors; the children are all well-nourished, and have never been seriously ill, except the exanthemata.

The patient, the youngest child but one, was a breast-fed-baby, weighing eight pounds at birth.

When the child was two months old the mother received a severe nervous shock and was ill for several months; nevertheless, she continued to nurse the baby.

When the child was four months old the mother noticed a few brownish spots on its neck; up to this time the skin had been perfectly normal. The macules were lentil-sized and did not appear to be accompanied by subjective symptoms. The mother paid but little attention to the eruption, until the spots gradually became more numerous, spreading to the shoulders and trunk; papules, ("small hard lumps") developed upon the site of the older macules ("stains").

When the child was brought for treatment to the Dermatological Department of the Long Island College Hospital she was a well-developed, bright and healthy child, with a good personal history; digestion was good and bowels regular; the heart, lungs, spleen and liver appeared to be normal; the child had never been jaundiced, and the only other skin affection present beside the xanthoma was an occasional attack of urticaria. Repeated examinations of the urine were negative, there was neither indican, albumen or sugar present.

The eruption appeared as saffron and orange-yellow colored tubercles upon the neck, shoulders, arms, trunk and limbs. Interspersed among these there were a number of brownish macules and a few hard, glistening, bright red papules; there were no lesions on the face, head, hands or feet, and at no time had there ever been xanthoma plaques about the eyes or in the palms of the hands.

The eruption was at all times entirely free from subjective symptoms.

Close observation of the case, over a period of nearly a year, showed that the lesions appeared first as a pea-sized, brownish colored macule, about a month later a small, pinhead sized papule developed upon the site of the macule; the papule was hard, smooth, glistening and pinkish red; it gradually enlarged, became darker in color and less firm in consistency, reaching its full development in about six weeks, when it was about the size of a large pea, soft and flabby in consistency so that it could be picked up and rolled between the fingers; it was no longer glistening but dull and furrowed, the color ranged from a bright lemon yellow to orange and saffron. The lesions, though closely associated, were always discrete, and kept constantly though slowly appearing. None of them have entirely disappeared, though some of them have shrunk and become smaller in size.

MICROSCOPIC EXAMINATION.

Sections were made from papules in different stages of development and imbedded in both paraffin and celloidin.

Those stained with osmic acid were unsatisfactory on account of the deep color; those stained with hæmatoxylin, and eosin showed up distinctly and clearly.

The lesion was situated almost entirely in the lower portions of the corium. the epidermis was practically unchanged, excepting for a deposit of yellow pigment in the rete mucosum and a thinning of the rete in spots due to the upward growth of the papillary layer and to the connective tissue hyperplasia.

The sweat and sebaceous glands showed no alteration; the corium was the seat of the principal changes found, most marked in the deeper layers.

The primary change appeared to be hyperplasia of connective tissue with subsequent fatty degeneration, this change varied in degree both according to the age of the tubercle and also in the same specimen, ranging from a beginning degeneration to complete

vacuolation with free fat in the lymph and connective tissue spaces.

These fatty changes show evidences of being those of degeneration and not an infiltration.

The xanthoma cells, large cells filled with fat and containing several nuclei, were found between the connective tissue bundles.

The blood vessels were thickened and surrounded by large and small transition cells. There was practically no change in the subcutaneous tissue.

During the time the patient was under observation, various means and remedies were used to remove the tumors and inhibit their growth, but nothing seemed to be of any use except the X-ray.

A selected area was rayed a number of times, and it seemed that the tumors became smaller and more flabby, the color also appeared to fade; we were unable to continue the treatment long enough to obtain any positive conclusions, but, judging from the rather uncertain results obtained in this case, and the one reported by Whitehouse (*Jour. C. D.* Oct., 1904) it would seem that a thorough course of radio-therapy is indicated in xanthoma, especially in the multiplex variety.

The case was shown at the Sixth International Dermatological Congress. When the patient was exhibited so that only the back and a portion of the chest were exposed showing only the pigmented macules, nearly all of the observers took it to be a case of pigmented urticaria; this diagnosis was strengthened by a co-existing attack of acute urticaria. Of course when the saffron colored tumors were seen the diagnosis was at once modified by all except a prominent English dermatologist who said to one of us that he thought a careful microscopical examination of the various lesions would reveal the pathological evidences of chronic pigmented urticaria.

This view was tentatively entertained until we had an opportunity to examine the lesions microscopically, for the history of several attacks of urticaria during the course of the disease and the urticaria present when the child was shown at the Congress led us to defer a positive diagnosis.

The last attack of urticaria was reflex, from the irritation of fleas, when they were removed it disappeared and there was no return while she was under observation.

The microscopical examination of the various xanthoma lesions dispelled all doubt as to diagnosis, for there were no evidences of wheal formation nor were there any mast-cells found, in short, all of the pathological changes were those of xanthoma new growths.

There have been a few cases reported where urticaria pigmentosa and xanthoma were concomitant diseases, but a careful examination of these reports makes one rather doubtful if some of these cases were not examples of urticaria pigmentosa with tumor-like formations.

The subject of xanthoma is of great interest to dermatologists because of its etiological obscurity, and a number of papers have been written upon this subject by some of the ablest cutaneous specialists of the world; but in spite of all that has been written or said we are still in the dark regarding the etiology of the disease and doubtful as to the identity or non-identity of the different types.

It is interesting to note the different causes of xanthoma that have been advanced by various authors.

When this disease first began to receive attention it was the almost unanimous opinion that it was due to some disorder of the liver, or as a sequel of jaundice, but later, when cases were reported where no disease of the liver was present, opinions began to vary.

Some claimed that the renal function was at fault, one reports a case occurring after renal colic, another after hepatic colic; two authors assert that both xanthoma multiplex and xanthoma diabetorum are of microbic origin. Asthma, emphysema, varicella, pentosuria and bichloride dermatitis have all been reported as preceding the xanthomatous eruption.

The majority of observers, however, agree that both the multiplex and the diabetorum types are due to some constitutional dyscrasia, that in one case may be influenced by glycosuria and in another by some entirely different factor.

It is evident, from the multiplicity of opinions as to causes, that the etiology of xanthoma is about as obscure as it was when the first case was reported.

It is not the purpose of this paper to discuss the merits of the various views regarding this etiology, nor to attempt to identify the different types, but to briefly state our conclusions after a careful study of the above reported case and the literature of the subject.

Xanthoma multiplex is rapidly ceasing to be one of the rare dermatoses, for we found nearly a hundred cases on record.

A little over one-half of these cases were in adults. In three of the children the disease was congenital, there being xanthoma tumors present at birth. Since so few of the reported cases gave any history of the affection being present in other members of the

family, we are led to believe that where the disease was found in two or more members of the family, it was a mere coincidence rather than a proof of heredity.

Jaundice was found in about one-twentieth of the cases under puberty while it, or some hepatic disease, was present in over one-half of the adult cases; the evidence of some hepatic trouble in fifty per cent. of the adults strengthens the belief in the hepatic origin of xanthoma, but it does not, by any means, prove it.

Only one child had xanthoma tumors about the eyes; three had involvement of the face, hands and feet; this finding was practically the same in the adult cases.

This, together with the reported histological differences, has led us to the conclusion that xanthoma multiplex is not identical with xanthoma palpebrarum, and that the three types are not similar except in clinical appearance: (i. e. the saffron colored) tumor.

Finally deducting from the study of our case and those of others we are inclined to agree with the claim that xanthoma multiplex is a distinct disease, a benign tumor of non-inflammatory origin.

PLATE XX—To Illustrate Dr. J. M. Winfield's Article.



FIG. 1.



FIG. 2.

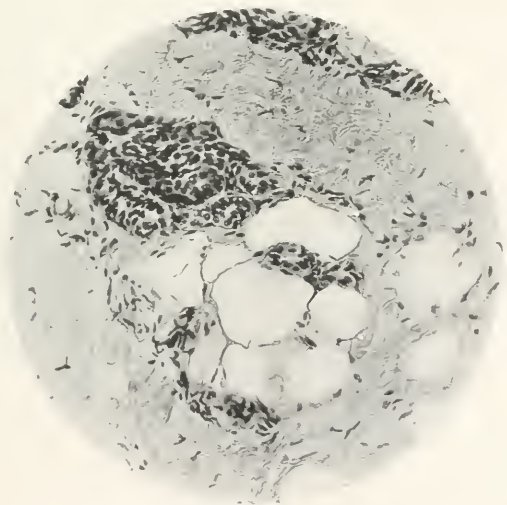


FIG. 3.

SOCIETY TRANSACTIONS.

THE NEW YORK DERMATOLOGICAL SOCIETY.

361st Regular Meeting, November 24, 1908.

Case for Diagnosis. Presented by DR. TRIMBLE.

The patient was a woman and the case had been shown before the International Congress of Dermatology in September, 1907. She was forty-eight years of age, and the skin affection had existed for twelve years. When she first came under observation the disease was practically universal. The skin was dusky, red, infiltrated, and profusely scaly. The itching was intense and had been so for several years. There was a certain amount of pigmentation of the forearms, and the soft parts of the hands and fingers were notably enlarged. Under treatment the disease has practically disappeared from the trunk, but at the present time the pigmentation of the forearms and the enlargement of the hands and fingers still exist, and there is a papular condition on the legs which seems to be follicular in character and gives to the hand the nutmeg-grater feel. A section of skin was removed and examined microscopically. The epidermis was slightly thickened and showed a hyperkeratosis, although here and there a few nuclei could be distinguished in the horny layer. There was a rather profuse subepidermic infiltration of round and plasma cells. The scaling is very slight at the present time, which is accounted for by the fact that the patient is using an oily preparation to control the pruritus.

DR. JOHNSTON considered it a case of pityriasis rubra pilaris.

DR. FORDYCE said he looked upon the case as one extremely difficult to diagnose, but one which had more of the features of a general lichenification of the skin. It suggested to him an affection due to some internal disorder.

DR. JOHNSTON remarked that the patient had been thoroughly inuncted with oil.

DR. ELLIOT said that an histological examination would be required to determine the diagnosis. It appeared to him to be a case of the so-called Darier's disease, but he could not say that positively without an examination.

DR. TRIMBLE, in closing, said that when he first saw the case he was inclined to make a diagnosis of *Lichen rubra acuminatus*. The patient was shown at the International Congress and no one there ventured a positive opinion. In reference to the suggestion of Darier's disease, he said that this diagnosis had not occurred to him. He was under the impression that in Darier's disease the itching was not such a marked symptom, anyway, not so intense and prominent a feature as was the case with this patient. The groins and axillæ were favorite locations for Darier's disease, and there was a peculiar secretion connected with the lesions. The disease in this patient was absolutely dry, had always been so, and showed no predilection for the axillary or inguinal regions. The microscopic section resembled lichen planus, no so-called psorperms were noticed.

Case for Diagnosis. Presented by DR. HOLDER

The patient was sent out from the public schools and was admitted to Randall's Island with the diagnosis of eezema of the head. Probably ringworm was suspected. Dr. Holder first saw the case after it had been in the hospital for two months, but could find no ringworm. The case was presented as a case with keratosis pilaris in a young child. There were lesions on the scalp, back of the neck, and legs. It has been treated formerly with green soap, which has kept the keratosis down. The most interesting lesion is on the back of the neck, below the scalp. In the daylight nearly every hair in this region and on the scalp has a collarette on it. Similar to that seen in some cases of ringworm. There is the same general condition of keratosis pilaris on the legs. The hairs seem to break off easily. The use of the green soap has been discontinued for the last ten days. In another month, perhaps the appearance may be changed.

DR. FORDYCE said that the case was undoubtedly one of koratosis pilaris, but it was a unique case in its situation and in its persistence from birth. It probably was related to the ichthyosis group of skin diseases.

DR. WHITEHOUSE agreed with Dr. Fordyce that it was a keratosis of unique type.

DR. HOLDER said that he would try to present the case again at the next meeting. The treatment with the green soap had formerly kept the hyperkeratosis down. This was the 10th day of development. The skin will be allowed to remain without application so that the case can be further observed.

Case for Diagnosis (Acanthosis Nigricans). Presented by DR. WHITEHOUSE.

This case was presented by Dr. Bulkley before the International Congress of Dermatology, and Dr. Whitehouse had promised to try and present it before this Society. She has ichthyosis-like areas, which have been pretty well kept down by bathing. She also has a migrating erythema in patches having a crescentic outline. Some of these are rather permanent, but most of them are evanescent, and will come up after a bath almost while looking at them, and then they will disappear. The patient is a little girl of six years, in whom these blackish areas of the skin resembling ichthyosis have existed since birth, developing around the neck, anterior axillary folds, both surfaces of the elbow and knee joints, and on exteriors of forearms and legs. The erythematous complication is only of six to eight months duration.

Several of the members agreed that it seemed to be a case of acanthosis nigricans.

Anaesthetic Leprosy. Presented by DR. WHITEHOUSE.

As the result of the treatment to which this patient has been subjected, the patches have nearly all disappeared, but the patient is suf-

fering intensely with a neuritis of the extremities, and she has been presented for therapeutic suggestions directed toward the relief of this condition. She has taken twenty-five drops of Chaulmoogra oil and ten drops of nux vomica after each meal for a long time. At first she took it with milk of magnesia, but now takes it with plain milk, which agrees better. As a result the patches have nearly all gone from the face and upper extremities, and on the lower limbs it has practically all disappeared. The trouble began ten years ago, and when first seen she had lesions all over the face, some of which showed infiltration; there were also at one time lesions in the mouth.

DR. SHERWELL inquired whether the patient had been given any anæsthetic hypnotic or narcotic. Opium might, he thought, be indicated for a little while at least, without patient's knowledge of its use to relieve the pain. It might also act as a tonic.

DR. WHITEHOUSE replied that she had had a little.

DR. ELLIOT said he did not understand why it could be called anæsthetic leprosy. When testing the patient she said there was the same amount of pain in the patches as in the skin where there was none.

DR. TRIMBLE had found a few nodules on the forearms and was inclined to think it a mixed type. He had made the test for anæsthesia with a pin, and had found a number of places where it was complete.

DR. SHERWELL said he had thought he noted some nodules on the ear, at junction of helix and lobe—but was not sure. There was evidently some abnormality there.

DR. WHITEHOUSE said that the anæsthesia of the lesions may have changed during the course of treatment. The patient was extremely nervous and it was very difficult to get correct impressions of the pin prick from her. When her mind is directed away you get very definite impressions, but not when she is taking careful notice of what is being done.

Answering a query from Dr. Holder as to whether the ulnar nerve was enlarged, Dr. Whitehouse replied that it was not excessively so.

Case for Diagnosis. Presented by DR. JACKSON.

The patient was a boy aged four years. At birth he was covered with an unusually thick layer of vernix caseosa. When that was removed by much soaking in oil, all the skin was left red, dry, and with many closely-adherent scales. That condition continued. At times the scales would heap up into thick plates. There was no history of like condition in previous members of the family, but a younger sister had a similar, though not so severe deformity of the skin. The boy's skin was red, dry, and scaly all over, even in the bends of the joints. His hands were markedly keratotic, with deep lines, and redder than the rest of the skin. Here and there at the bends of the elbows little spines projected from the skin. The eyelashes were missing and there was a tendency to ectropion. His health was said to be good, although he was inclined to take cold easily. He had been presented before another Society and several of the members had made a diagnosis of dermatitis exfoliativa. The diagnosis of pityriasis rubra pilaris had also been made.

Dr. WHITEHOUSE considered it a case of ichthyosis. The redness might depend upon the treatment, but independent of treatment we sometimes see cases of ichthyosis very much reddened. Dermatitis exfoliativa is a deeper seated affection, and the general health becomes impaired when the exfoliation of the epidermis becomes complete. This child is several years old and is in very good condition and she has had this condition since birth, preceded by a severe vernix; all the signs seemed to point to a diagnosis of ichthyosis.

Dr. THIMBLE was disposed to consider it a case of dermatitis exfoliativa, although it was said to be congenital. The generalized redness of the skin and the fact that the flexures of the elbow joints and the popliteal spaces were affected in this case were the reasons for making this diagnosis. The locations mentioned were practically always free from disease in ichthyosis. This patient's skin was inflammatory over the entire surface, a most unusual thing in ichthyosis unless due to some other cause.

Dr. JACKSON said he had made the diagnosis of ichthyosis when he saw the patient at the Vanderbilt Clinic. He had presented it for confirmation of his diagnosis. The other ichthyotic presented this evening, the woman, showed similar though not as pronounced changes of the skin of the face and palms.

Ichthyosis. Presented by Dr. SCHWARTZ.

The patient was presented not so much on account of the interest in her own case, which was a plain one of well-marked ichthyosis, as in the history of her numerous pregnancies. There was no history of skin disease in her family on either father's or mother's side. She has seven brothers and sisters, none of whom have any skin disease. She herself has always had this condition, and apart from that her personal history is of no interest until the time of her marriage at the age of twenty. Since then she has had six pregnancies.

1st. Pregnancy. A male child born at full term. From the mother's description it was evidently born with a well-marked condition of ichthyosis congenita. It died at the age of twelve days.

2nd Pregnancy. A female, born at full term. She is the elder of the two children presented this evening, and seems to be perfectly normal, both mentally and physically. She has no sign of skin disease.

3rd Pregnancy. A male child, born at full term. He is now four and one-half years old, and is also presented this evening. When first seen, two years ago,—that is, at the age of two and one-half—he was just beginning to talk and was very backward, both mentally and physically. He was very dull and heavy looking, the face was broad, nose flattened, complexion pasty. The skin was perfectly normal. The thyroid gland was not palpable. The absence of the thyroid in a case of ichthyosis congenita as reported by Winfield, suggested the possibility that the general backward condition, mental and physical, of this patient might be due to insufficiency of the thyroid. Thyroid feeding was tried at the time, but the child was lost sight of very shortly afterward, so that no conclusions could be drawn. As seen now, he is still considerably undersized, and does not seem to have the mental development to be expected at his age.

4th Pregnancy. Male child, born at full term and showed fully developed ichthyosis congenita when seen by me after death on the second day. The skin was brownish-red, thick, and glazed—looking and feeling like a piece of old parchment. There was a deep fissuring at all the flexures, ectropion, puckering and fissuring of the mouth, deformity of the mouth and ears, etc.—in all respects corresponding to the so-called “harlequin fœtus.”

5th Pregnancy. Miscarriage at six months.

6th Pregnancy. A male child, born at full term, with fully developed ichthyosis congenita. It died on the fourth day.

Unfortunately, it was impossible to obtain permission for an autopsy in either of the cases observed.

DR. JACKSON said that it was an extremely interesting series of cases, showing the hereditary character of the disease. If it is true that no ancestor of the parents had had the disease, here we may have the beginning of a race of ichthyosis. It would be most desirable if we could keep track of this family.

Lesions of the Hands and Face. Presented by DR. WINFIELD.

The patient was a female, aged thirty-six. Was first seen by him three years ago at the Kings County Hospital. The disease she sought relief for then, was what appeared to be a rosacea, there was a vague history of syphilis. She left the hospital and after a while entered Dr. Bulkley's service at the Skin and Cancer Hospital. There the diagnosis was made of lupus erythematosus involving the hands and face. About a year ago she came to the dermatological clinic at the Long Island Hospital. The face and hands, especially the fingers of the right, were erythematous and in some places covered with minute scales. The erythema is not permanent, but comes and goes, lasting sometimes for a month and then clearing up and remaining apparently well for some time, this feature was more marked of the hands. She is highly neurotic, close questioning did not disclose any history of syphilis. The only treatment that seemed to influence the disease at all was upon one occasion the iodide of potash—and on another ergot, at the present time her condition is better than it had been for years. The face shows a number of atrophic scars like those after necrotic granuloma, and the hands bear a marked resemblance to lupus perneo. The case was shown for diagnosis as he did not feel sure of it being lupus erythematosus.

DR. WINFIELD said that when he first saw the case two or more years ago she did have some acne-like papules on the face, and there was also a general flushing and some dilated capillaries, but she was in the hospital such a short time that nothing definite was made of the case. When she came to the Long Island College Hospital Dr. Potter, his assistant, learned that her husband was in the insane asylum, and suspecting that

syphilis might be the cause of the husband's insanity, and this give a clue to the woman's disease, investigated, but could get no history of syphilis in either party. She says she had acne as a young girl. He said he had not seen the patient since August until to-night, and since that time she had moved to the suburbs and apparently the change has greatly improved her general condition.

Dr. FORDYCE said that he agreed with the diagnosis of lupus erythematosus, but that it was a very unusual type.

Dr. JONSSON said that the history of rapid appearance and disappearance ought to dispose of lupus erythematosus. The lesions are deeper and the scars are irregularly stellate. If it were desired to give it a name he thought it would properly fall in the class of papulo necrotic with lupus erythematosus. The lesions of the hands, he would characterize as lupus pernio.

Tuberculosis Verrucosa Cutis. Presented by Dr. WINFIELD.

Mrs. S. Widow, aged forty-five. When she was twenty-five years old a small warty ulcerated patch appeared upon the right wrist, which gradually spread until the whole wrist was involved and extended from the hand almost to the elbow. The first warty patch was removed shortly after it appeared. This particular area healed and remained so until about six years ago. Her husband was a consumptive and she attended him until he died, which was about fifteen years ago. A piece of the growth was excised and submitted to the pathologist, who pronounced it to be tubercular. The treatment had been tonics and, locally, compound creosote plaster. X-Ray had been used for a year and a half but the case had grown rapidly worse.

A Red Scaling Eruption of the Neck, Shoulders, Arms and Trunk.

Presented by Dr. J. A. FORDYCE.

The patient was a man about forty years old, who presented himself to the Clinic with the scars of an old favus of the scalp. At the same time he had an ill-defined scaling eruption over the neck, arms, and trunk. This condition had existed for some years. The scales, after having been examined several times, were found to contain branching mycelium and some spores, which suggested the connection of the skin lesions with the old favus of the scalp.

A similar case had been under observation last year at the City Hospital, where an active favus of the scalp was associated with persistent scaling lesions of the neck and arms. In this case microscopic examination was not made.

Dr. WHITEHOUSE thought that if the generalized condition was due to favus it would have yielded to treatment, as such cases generally respond promptly. Probably the fungus found was an intercurrent growth.

Dr. TRIMBLE said that he had seen the case on several occasions and the condition to which Dr. Fordyce referred was present until some oily preparation

was applied which removed the scales. Two examinations were made and nothing found, but on a third examination some mycelia were found.

Blastomycosis (?). Presented by DR. SHERWELL.

Eugene McC.; age fifty. When first seen, October 21st, the patient had suffered with the same general condition for nearly a year. The trouble commenced simultaneously on the middle tibial region of both legs. The patient was in a pitiable state, having this papulo-verrucose and infiltrated condition on the anterior and posterior portions of both legs. He had been neglected, and had not seen a doctor for some time. At the time seen larvæ and maggots had been generated, and the limbs were in a disgusting condition. A diagnosis of blastomycosis or tuberculosis verrucosa cutis was made. He was given a wash of bichloride to use and Iod. Potass internally. The patient was a man of immense muscular development over whole frame, and his legs were œdematous, but all the swelling was not due to simple œdema, nor to the inflammatory condition. He did not regard it, however, as elephantiasis. The man has been used to heavy work, and has been doing it up to the present time. It had been impossible to make microscopic examination, and it was thought that the members would be interested to see the case in its present state, and to give opinions as to diagnosis, which he, Dr. Sherwell, believed personally to lie between Blastomycosis and tuberculosis verrucosa cutis.

DR. WINFIELD said he had not seen the case before, but he did not think it to be one of blastomycosis, but was rather inclined to diagnose it as a vegetating dermatitis, primarily and eczematous condition due to the existing elephantiasis, and thought that rest and tight bandaging would help if not cure the disease.

DR. JOHNSTON said that it did not seem to have a blastomycotic appearance, but was more like an elephantiasis with a characteristic warty outgrowth.

DR. ELLIOT agreed with Dr. Johnston.

DR. FORDYCE said that if elephantiasis secondary to a tuberculosis verrucosa cutis could be eliminated, one would think next of dermatitis vegetans, and called attention to a case which had been under his observation for some years in which a similar condition had followed a dermatitis herpetiformis. It was his opinion that the majority of cases of dermatitis vegetans were secondary to other affections of the skin and caused by staphylococcus infection.

DR. JACKSON said that clinically he regarded it as a vegetating dermatitis. The man had varicose veins which predisposed to elephantiasis condition of the legs, and lowered the resistance of the tissues to the effect of traumatism. A slight injury set up a dermatitis and some kind of secondary infection produced these vegetations. The fact that the condition is symmetrical is against the diagnosis of blastomycosis.

DR. WHITEHOUSE said that the case reminded him of another seen by him eighteen years ago in private practice on the East Side—a woman weighing 400 pounds. She was only 22 years of age and unmarried, and was truly elephantine, and sat in a chair from one end of the year to the other. She had vegetations similar to this case, and in addition some oozing nodules further up on the thighs, which were exceeding painful. It was as foul smelling as this one.

The vegetations got well by putting her to bed and giving diuretics—digitalis, calomel, and other eliminants, as the result of which she passed enormous quantities of water. She went down nearly a hundred pounds in weight, the pain ceased, and by strapping applications of antiseptics and bandaging, the vegetations also disappeared; it was the only case like this that he had ever seen. He was inclined to eliminate the question of blastomycosis. He thought that if the patient were sent to a hospital and put to bed, and some of the water eliminated he would have a chance.

Dr. SHERWELL said that the dense exudate and the peculiar character of the general condition incline him to believe that this was possibly blastomycosis. He recognized that the man's lower limbs were enlarged, but he was a man of great musculature all over his body—while his arms were large they were well proportioned. He agreed with Dr. Dade that the disease was a vegetating dermatitic inflammation, and that that was primary. The peculiar exudate, the beading, the popular character—differ from what is generally found in cases of excessive elephantiasis. If the lesions of this character had occurred on the foot and more pendent portion of lower limb and foot he might think so, but the vegetating dermatitis, whatever the original course, was the secondary and not the primary condition. The almost fixed condition of the lower limbs he has to sleep even in a reclining position, he thought had a good deal to do with the enlargement. He has improved considerably under the lotion spoken of, and fair doses of Potass. Iod.—this may, however, have acted as Dr. Whitehouse has suggested as a diuretic.

Late Hereditary Syphilis. Presented by Dr. WINFIELD.

The patient was a man twenty-four years of age. When sixteen years old, he had a small ulcerated nodule on the right side of the nose near the lower border of the alæ. The ulcer enlarged until the inside of the nose and pharynx became involved, about the same time a sluggish inflammatory swelling appeared at the joints of the left index finger and there was also an ulcer about as large as a fifty cent piece on the top of the right foot. The diagnosis of tuberculosis was made and the finger was amputated. The ulcer on the foot healed, but that of the nose continued without much change. He was seen by several physicians, who treated him for lupus, the treatment consisted of curetting, cauterization and the X-ray. The nasal condition failed to respond; finally he was sent to New Mexico, but without any result. Dr. Winfield saw him in the spring of 1908, and after watching the case for two or three weeks put him on anti-syphilitic treatment, the response was rapid and satisfactory, so that now at the end of six months his skin and mucous-membrane lesions are entirely healed. There is no personal history of syphilis, but his father, who is dead, gave a history of having had this disease, and the mother had had several miscarriages.

Case of Lichen Planus. Presented by Dr. WINFIELD.

This is a case of lichen planus involving the mouth and body. The inside of the mouth, the cheek, and the lips are affected. The condition has existed for six weeks and the patient's family physician had him under arsenic treatment.

DR. FORDYCE said the case was very similar to one which he had seen a few days before. In that case first lesions were on the glans penis, then the abdomen and finally the mucous membranes. The lesions on the tongue were very like those of leukoplakia, but inside the cheeks individual papules making up the patches could be defined. On account of the slight itching and primary involvement of the genital organs, a general practitioner might be excused for calling such a case syphilis.

NEW YORK ACADEMY OF MEDICINE.

Section on Dermatology.

Stated Meeting Held October 6, 1908.

DR. A. R. ROBINSON in the Chair.

Cases Previously Shown. Syphilis of the Breast. Presented by Dr. LAPOWSKI.

This case was presented on the 3rd of March, 1908 (see the *Journal of Cutaneous Diseases*, 1908, xxvi, 372), before the Section with the diagnosis "Large Gumma of the Breast." The diagnosis was questioned and carcinoma was suggested with the advice "to put the patient under antisyphilitic treatment for from three to four weeks, and then, unless great improvement had taken place, to amputate." On the 10th of March the tumor measured $7\frac{1}{4}$ ctm. in transverse diameter, $7\frac{1}{4}$ ctm. in vertical diameter and 17 ctm. in circumference. After one injection of calomel and one of salicylate of mercury salivation developed on the 8th of April. Treatment was stopped and the patient was not seen for twenty days, when she appeared with the tumor round, movable, increased in size, painless, the upper part hard, the skin telangiectatic. Above the nipple there was a red, dry, slightly hypertrophied patch. The size of the tumor increased in vertical diameter to 12 ctm. She was given inunctions, and potassium iodide up to 150 drops of saturated solution daily, and two injections of salicylate of mercury during April and May. At the end of May the size of the tumor was not diminished, the skin near the nipple was red, infiltrated and adherent. Several soft areas were noticed in the tumor, covered with normal skin. The telangiectasis was more developed. The patient's weight increased. On the 5th of June, on the 15th and on the 25th, calomel injections were given. At the end of June there was still no improvement in the size or aspect of the tumor. Treatment was stopped. In the middle of August a slight decrease in size of the tumor was noticed, and on the 20th of September the whole mass in the right breast entirely disappeared, leaving only a slight discoloration of the skin. There was a deep concavity in the place of the former mass: passing the finger over the skin one could feel the ribs, and the whole mass of the breast seemed to be absorbed. Only a slight infiltration and a slight redness remained around the nipple. There were no enlarged glands. The condition since September has im-

proved still more. The discoloration of the skin is disappearing, and the patient has gained fifteen pounds in weight. This case proves, that in such cases only a very active specific treatment administered for months is to be taken in consideration when the diagnosis is to be made *ex juvantibus*.

Tuberculide. Presented by DR. LAPOWSKI.

This case was presented Feb. 4, 1908 (see this *Journal*, 1908, xxvi, 324).

I bring this case again to your attention to show that the macules undergo changes; some of them have tiny scales, some on the breast have disappeared, leaving minute scars. There also can be seen on the trunk flat, lichen-like shiny papules, which also leave scars. The follicular necrotic lesions are very pronounced, especially on the thighs. The macules, the scars and the follicular necrotic lesions are the result of the same process and cannot be regarded as a congenital process—a disseminated naevus. The case belongs to the class of tuberculides—presenting in the same patient several varieties: a process on one hand in some way similar clinically to lupus erythematosus and one on the other to folliculitis necrotica.

New Cases. Lupus Erythematosus. Presented by DR. A. R. ROBINSON.

The patient is a female, blonde, well nourished, age twenty-three years. There is no tuberculosis in the family. The disease commenced three years ago as a small spot on the left cheek near the center, followed soon afterward by a similar lesion on the right cheek, and later by two others on each side alongside of the nose, and a few weeks ago a new lesion formed over the left malar prominence. The lesions range in size from that of a pea to an area one inch in diameter, differing from the ordinary form of erythematous lesions in that the principal feature is congestion with dilated blood vessels, with no scaling and only an indication of scar tissue formation. The smallest lesion could be called an example of the telangiectatic form.

This case, therefore, is presented as an example of lupus erythematosus in which the changes in the vascular system are the marked ones, whilst the corium shows but little change.

Ulcer of the Back of the Hand. Presented by DR. LAPOWSKI.

The patient is a girl, about twenty-five years old, a nurse. Two months ago while putting in order a patient's bed she scratched the dorsal aspect of the left hand. The patient died from typhoid and rephritis, but during his stay in the hospital there developed patches on his tonsils and the nurse was in the habit of cleaning his mouth. The character of the patches was not determined either during life or after death. Three days after the scratch the ulcer developed, remaining since, and increas-

ing constantly in size. Various remedies and irritants were used, including three exposures to the X-ray, but there was no improvement. Two weeks ago the patient was first seen by me. The ulcer was longitudinal, the long diameter in the direction from left to right 3 cm., the short diameter $1\frac{1}{2}$ cm. The edges were infiltrated, raised, sharply defined, clean cut. The floor was cribriform, slightly purulent, and, easily bleeding in some portions, the dark grayish membrane was firmly adherent to the floor. The whole ulcer was hard to the touch, painless. There were no enlarged glands. The body and mucous membranes were clean. No *Spirochæta pallida* (Giemsa's stain) could be found. Under the application of a solution of boracic acid the ulcer diminished in size, and it is now round instead of oval. The condition has remained stationary for the last eight days. The whole appearance of the ulcer suggests very strongly an *ulcus durum*.

Favus of the Arm. Presented by Dr. LAPOWSKI.

The patient is a girl, twenty years old. The diagnosis was made when the characteristic favus crust was present. The present thin, whitish scab is only of forty-eight hours' duration: pin-head yellowish points can be seen through the thin scab, corresponding with yellowish conglomerations around some hair follicles. The hair and nails are normal.

Miliary Gummata of the Lip and Palate. Presented by Dr. LAPOWSKI.

The patient is a man about 50 years old. He had an *ulcus durum* fifteen years ago. He had only six months' treatment, when early manifestations were present, and no treatment since. The present lesions appeared eight months ago. The right portion of the upper lip is swollen to three times its normal size. Pin-head to pea-sized gummata, arranged in circular and semi-circular patches are scattered over the skin and mucous membrane portion of the lip. The inner cheek, and the hard and soft palate present one mass of pea-size gummata. The whole patch is surrounded by a raised infiltrated border. There are no enlarged glands.

Rodent Ulcer of the Lip; Results of Carbon Dioxide Treatment. Presented by Dr. GORTHEIL.

Richard S., policeman, aged 51. Has had small persistent scabbed sore on his lower lip for fifteen years. During the last year it has increased considerably in size, and has bothered him a good deal. No treatment. Does not smoke. Picks off the scab all the time, and unconsciously licks the sore.

Examination May 15th, 1908. A little to the left of the center of the lower lip is a superficial ulceration with characteristic moderately hard pearly edges. Until September was treated with the X-ray. Cornell tube, cautiously, as I was well aware of the dangers of treating the mucosa

in this way. Moderate reaction once; no improvement in the sore. September 15th, solid CO₂ applied for sixty seconds with moderately firm pressure. A good blister formed; treatment with boric acid wet dressing. October 5th: Ulceration healed; part feels perfectly well; hardly any induration left. Margins still look suspicious. Not presented as a cured case. Resemblance in results to those in X-ray cases to be noted.

Lupus Erythematosus. Presented by Dr. KINGSBURY.

The patient is a mulatto woman 40 years of age. She was born in the West Indies, but has lived in this country for the past sixteen years. Married nineteen years ago and is the mother of six children. No miscarriages. The patient had an attack of pneumonia seven years ago. She has been troubled at times by certain rheumatic symptoms, but states that otherwise her general health has always been fairly good. No tuberculous history. Physical examination showed the lungs to be normal and a negative result was obtained by the conjunctival tuberculin test. *Urinalysis:* Sp. gr. 1012, clear, acid, amber, no glucose, very faint trace of albumen. The eruption began to develop about two years ago. The ears were first affected, but after a few months lesions appeared in the scalp and these rapidly increased in size. There is said to have been considerable pruritus at this time. Patches appeared on the cheeks and nose about one year ago. At present nearly the entire scalp is involved. In places there is evidence of an active process, but for the most part the scalp shows only the characteristic cicatrization of the disease. The scalp is denuded of hair except at the occipital region, where a few scanty locks remain. The ears are hard, thickened, and covered by closely adherent scales. On each cheek there is a depressed circular patch about one and a half inches in diameter. The patches show atrophic change in the center and are surrounded by an increased deposit of pigment. A somewhat smaller patch on the bridge of the nose is similar in appearance to those on the cheeks.

Recurrent Summer Eruption. Presented by Dr. WILLIAMS.

The patient is a regress 17 years of age. She has had measles, scarlatina, and diphtheria. Her bowels are constipated. Her circulation is poor, the hands and feet being usually cold. Otherwise her general health is good. The present eruption appeared when she was about three years old, and has recurred every year since with the beginning of the warm weather, improving or disappearing in the winter. The eruption occurs especially on the shoulders, forearms, hands and legs, and slightly around the waist. The earliest lesion is a small papulo-vesicle, subsequently enlarging to about the size of a pin head. Older lesions are scratched and scabbed papules, which gradually disappear, leaving a permanent light colored scar. The case seems to be an example of the disease described by Crocker under the title of dermatitis recurrens.

THE PHILADELPHIA DERMATOLOGICAL SOCIETY.

The regular monthly meeting of the Philadelphia Dermatological Society was held at the Jefferson Hospital, on Tuesday evening, November 24, 1908, at 8:30 o'clock. Dr. M. B. Hartzell presiding.

Urticaria Pigmentosa, A Case of. Presented by Dr. KNOWLES.

The patient was rather a delicate and anæmic looking girl of eight years, and according to the mother had had this condition for only two years. The case had been under observation at irregular intervals for five months, at each visit an acute urticarial outbreak being noted. Most of the lesions are pea in size, a few are as large as an almond, they are yellowish-brown in color, typical wheals, slight infiltration can be felt with the finger, a linear arrangement following the lines of cleavage of the skin is noted. Fresh wheals appear daily. There is intense pruritus, numerous scratch marks being present. The one hundred or more lesions are distributed on the shoulders, the upper arms, the chest, the abdomen, the upper and the lower portion of the back, the buttocks, and the upper part of the legs.

Pictures of another case of urticaria pigmentosa were also presented, the child being two years of age. The condition originally started at three months of age, the face and the scalp, as well as the trunk and the extremities, were attacked.

A picture of a probable case of pigmented urticaria was also exhibited, but as there were no active lesions but only pigment marks present, the diagnosis as yet cannot be proved.

Erythema Induratum (Bazin), A Probable Case of. Presented by Dr. HARTZELL.

The patient exhibited was a slender, pale girl of 19 years. She had been healthy with no skin outbreak until two and one-half years ago when the present eruption appeared. The disease started as a small patch on the dorsum of the right foot, which spread until at present there is a palm-sized lesion, bluish-red in color, with a somewhat rough surface, a somewhat circinate but ill-defined border; in the center of the patch there is an irregularly shaped, one-quarter-dollar-sized ulcer, with a somewhat sero-purulent discharge. There are also several circinate and deeply pigmented scars on the posterior surface of the lower leg, on either side of the tendo-Achilles. The patient complains of cold hands and feet, particularly of the foot affected, the extremities are slightly bluish in color. There is a considerable amount of pain in the involved foot, particularly at night.

Lupus Erythematosus, A Superficial Case of. Presented by Dr. KATZENSTEIN.

The patient was a woman 40 years of age. She had first noticed the

present eruption one year ago. A small red, slightly scaly spot first appeared on the vertex of the scalp, gradually becoming larger until now it is silver-dollar in size, reddish in color, denuded of hair, with minute openings of the ducts on the surface, and slightly scaly. There is another patch almost as large and of the same character on the right parietal region. The cheeks and the areas behind the ears are bright-red, slightly scaly, and the capillaries are seen to be dilated. Pigmented areas are found on the forehead and the sides of the neck, the skin in contact appearing unusually pale in color. The arrangement of the pigment is somewhat linear.

Herpes Zoster Involving the Palm of the Hand, A Case of. Presented
by Dr. KNOWLES.

The patient exhibited was a boy of 12 years, the outbreak being of five days' duration. The first thing noted was slight pain in the right arm and hand; this was followed in one day by the appearance of pin-point vesicles, which soon became pea in size; there were about a dozen lesions in each group and they were situated on a slightly erythematous base. There were about a dozen groups of these vesicles in all, several patches being located on the forearm, one at the bend of the elbow, and several on the extensor and flexure surfaces near the wrist; there were four groups on the palm of the right hand, one on the thenar, another on the hypothenar eminence, and two at the junction of the phalanges with the metacarpal bones; two other patches were seen between the index and middle fingers, and between the middle and the ring fingers, and the last was found on the ulnar side of the dorsal surface of the hand. Because of the distribution of the groups of vesicles several nerves must have been involved, probably the median, the ulnar, and the radial. Considerable pain was complained of by the patient.

Arsenical Keratosis, with Multiple Epitheliomata, An Extensive Case of.
Presented by Dr. SCHAMBERG.

The patient exhibited was a man 65 years of age, with multiple cancers of the skin due to the long continued use of arsenic. The case was the same as that reported before the American Dermatological Association in 1906. The patient had been given Fowler's solution at intervals during a period of twenty-five years for psoriasis. At times he has taken as much as thirty drops of the solution a day for three months. As a result of a cancerous growth upon the left thumb, the arm had been amputated above the wrist. The patient has over the entire back scores of lesions varying in character from reddish keratotic patches to well-defined elevated epitheliomata of finger nail size. In addition, there were pigmented patches scattered here and there. Upon the scalp and the right wrist there were two fungating epitheliomata of about the diameter of a centimetre. The palms and the soles presented the classic appearance of

chronic arsenicism. Several patches over the abdomen apparently were psoriatic. The patient has a ruddy color of his cheeks, and his general health at the present time is good.

Erythema Elevatum Diutinum, A Case of. Presented by Dr. STOUT.

The patient presented was a small sized girl of 12 years, and the condition had lasted three months. On the index finger of the left hand there was a sharply marginate patch, an inch and one-half by one-quarter inch, extending from the metacarpo-phalangeal articulation to the junction of the second and third phalanges, it was red, with a raised border, made up of individual, pin-head sized papules, and with a somewhat depressed center. Another patch of the same type, three-cent-piece in size, was situated at the base of the ring finger, on the dorsal surface. On the outer side of the same hand two dime-sized patches with the same characteristics were found. On the right hand two pin-head sized patches were found; at the base of the right thumb there was a three-cent-piece sized lesion, and also a patch one inch by one-quarter inch. Three pin-head-sized lesions of the same character as those described were seen on the elbow. With the exception of slight itching and burning there were no subjective symptoms. The child had been excluded from school, the examining physician having diagnosed the case as ringworm.

A Case for Diagnosis. Presented by Dr. STOUT.

An extremely interesting case was presented for diagnosis, the patient being a woman of 67 years. The condition started seven weeks ago with the development of a nodular lesion on the palm of the left hand; this softened, broke down, and discharged a pus-like fluid. Three weeks later the chain of lymphatics extending up the inner side of the arm to the axilla became involved; a red spot would first appear, this would become infiltrated, the skin would break and an ulcer would be formed. This condition was progressive, until at present there are fully a dozen dime-sized ulcers, somewhat punched-out, reddish in color, with a sero-purulent discharge, all connected with the lymphatic cord which can be felt like thick twine to the palpating finger. Numerous nodes can be felt subcutaneously on this lymphatic cord which probably will take the same course as those lesions which ulcerated; new nodules are still appearing. On the left knee there is a hazel-nut sized lesion of the same character as the others. The lymphatic glands in the left axilla are not involved. There is no cough or rise in temperature. The patient resides in New Jersey, where she is a berry-picker.

Dr. Stout suggested an original infection in the palm of the hand, probably while carrying on her occupation.

Dr. Schamberg suggested that it was probably a form of blastomycosis of a subcutaneous type. He referred to the case of almost exactly the same character that was presented by Dr. Davis, at a former meeting of the society.

Dr. Hartzell said he thought a diagnosis could not be positively stated until a microscopic examination was made.

Dr. Stout suggested an original infection in the palm of the hand, probably ciety at the next meeting.

Acne Vulgaris Limited to the Right Shoulder, A Case of. Presented by Dr. SCHAMBERG.

The patient was a male of 59 years, with a history of having applied a plaster to the right shoulder last June at the site of a fracture. The present eruption developed immediately after the removal of the plaster; the lesions were noted over the deltoid, the scapular region, and on the right upper half of the back; there were about fifty typical acne papulopustules. Excepting about one-half dozen acne lesions on the left side of the upper back, the body was free of eruption.

Papulo-necrotic Tuberculid, A Case of. Presented by Dr. STOUT for Dr. WALLIS.

The patient was a male of 21 years, with a history of pulmonary tuberculosis for three years; he had been treated two years at the White Haven Sanitarium, remaining there for nine months. Although the patient is somewhat pale and emaciated, he stated that his health has improved during the last two years. The skin condition originally started four years ago with the outbreak of reddish papular lesions on the dorsal surface of the hands and wrists, these increasing in number and general distribution. At present there must be in the neighborhood of a hundred pin-head to pea-sized lesions on the lobes of the ears, the tip of the nose, the dorsal surface of the hands, the extensor surface of the forearms, the lower legs and the knees, and between the shoulders. The lesions are somewhat raised, bluish-red to bright-red in color, with a slight pustular point in the center, there is a slight inflammatory areolar around some of the lesions; a black eschar forms on these lesions, giving rise to pitting and scarring. The hands, the feet, and the ears are cold and tingle when it is even moderately cool; the ears are somewhat bluish in color.

Acnitis (Previously Shown). Presented by Dr. SCHAMBERG.

This patient had been presented to the society on several occasions and his case had been reported in detail at the last meeting of the American Dermatological Association. The active lesions have, excepting the scarring, disappeared. There have been a few subcutaneous abscesses on the face. Linear lesions are noted on the upper eyelids. There is a slight keloidal tendency on the forehead.

FRANK CROZER KNOWLES, M. D., *Reporter.*

MANHATTAN DERMATOLOGICAL SOCIETY

69th Regular Meeting, May 1st, 1908.

A. BLEIMAN, M. D., Chairman.

Pemphigus Puriginosus. Presented by DR. W. S. GOTTHEIL.

Mrs. H. S., aged 30, married 10 years, 2 children, no miscarriages. During Jan., 1908, both children had pneumonia: patient nursed them and was very much run down. Towards middle of February present eruption appeared for first time. In the beginning the skin lesions were described as uticularial and later changed into a diffuse papular eczema. Patient was first seen by the speaker on April 23, 1908, and presented the following condition.

Moderately anaemic, otherwise in fair general condition. Practically her entire integument, with the exception of the skin covering both popliteal spaces and lower legs, was the seat of discrete lesions or their remains. Nine-tenths of the efflorescences were the remains of past lesions, appearing as pea or bean-sized spots, some covered with dark and blood stained crusts, but most of them were stained superficial scars in various stages of retrogression. Each one of these marked the site of a pre-existing lesion. At several place were groups of fresh lesions that had appeared during the last 24 hours, or were coming out at the time the patient was presented. The patient affirms that every one of the lesions of the past had come in the same manner. Thus on the ulnar surface aspect of the dorsum of the left hand were a group of some 12 or more vesicles filled with a clear serum. Most of these vesicles were small and round: but five of them were pea-sized or over and elongated in shape: three of them were narrow, oval, and a quarter of an inch in length. The patient believes that the vesicles would be much larger if left to themselves; but she had been in the habit of pricking and emptying them as soon as they formed. On several other parts of the integument were precisely similar new groups of vesicles; in one or two places the patient pointed out groups of erythematous and urticarial-like areas, which she affirmed would become vesicles in a few hours. In one place, in fact, with the aid of a lens, one could recognize the beginning of vesicle formation at the apex of an urticarial lesion. The itching of the primary uticularial lesions is intense, and the patient knows very well when and where a vesicular outbreak is about to occur. Scratch marks and eczematous patches were apparent at various places.

On April 30th, the patient was seen a second time. She felt very much better, especially after baths. No new vesicles at the time, but there was a number of new groups of small circular excoriations, notable on the side of the nose and on the back and shoulders.

The case was presented as one of *Pemphigus puriginosus*, and iden-

tical with the old Pompholyx of Willan. The diagnosis is made on the facts of the sudden and general onset, the smallness of the clear serum filled vesicles, their appearance on an utiearial or erythematous base, and intense itching. The secondary pigmentation of the skin has not had time to occur. Dermatitis herpetiformis is excluded, from the areas of skin affected, the absence of distinct grouping, and the age of the patient at which the affection has appeared.

Serpiginous Epithelioma of Forehead and Face. Presented by DR. ABRAHAMS.

Male; aged 64 years, Bohemian, cigar-maker. Family history negative. Personal history. Was always in good health. No specific history. Present health is excellent. Four years ago, with a lighted cigar, accidentally touched upper part of face, in right maxillary region, causing a small circumscribed sore which refused to heal. A few weeks later, "blebs" appeared in the region of the burn; these lasted two weeks and disappeared without any treatment. In spite of treatment the sore began to spread slowly.

The presenter saw the patient for the first time about the middle of March. The condition remains practically unchanged. About one inch above left eyebrow was a small though deep ulcer with a ragged edge, and discharging a sero-purulent secretion from its lowest angle. The rest of the lesion was covered with a thick, dirty grayish crust. No papules, nodules, nor any signs of irritation were present around the lesion. No subjective symptoms. A similar, but very much larger, ulcer existed at the upper part of the right cheek. The entire lower lid is gone; the ulcer extends from the inner to the outer canthus. The lesion is about two inches in length and one inch in width. The eye itself is but little affected, but owing to exposure the vessels of the conjunctiva and of the upper lid are deeply injected. The general features of the ulcer are the same as the one on the forehead. The only subjective symptom is frequent to almost constant lachrymation.

Giving the man the benefit of the doubt, he was given thirty grains of potassium iodide three times a day and one quarter of a grain of protoiodid of mercury four times, and a mercurial plaster was applied locally. Little or no improvement resulted. The patient will be submitted to the X-rays and results reported at some later meeting.

Lupus Vulgaris of the Face. Presented by DR. ROBERT ABRAHAMS.

Eight years ago the patient was treated for a small area of lupus vulgaris of the left side of the face near the ear. The nodules were curetted and the bases were cauterized. In the course of two weeks the boy was discharged apparently cured. The history since then is as follows: Shortly after his discharge the nodules reappeared. Ulceration set in, and the disease slowly spread so that at the present time it occupies about one third of the left side of the face. Typical nodules

are present all around the margin of an ulcerated, granulating area. The patient was put upon mixed treatment and the ulcer epidermized, but the lupoid nodules were unaffected and are still present.

Pityriasis Rubra Pilaris, in Colored Female. Presented by DR. E. L. COCKS.

M., aged 15, colored; came under observation at the Harlem Hospital Dispensary on April 23, 1908. In the early part of March of this year a neoplasm was removed from the axilla. One week later the present eruption appeared. No rise in temperature. The entire integument is involved. The patient first noticed that the legs were rough; this roughness slowly spread upwards until the face became involved. The palms and soles did not become affected. The nails are not involved. There is no pruritus. On the face and trunk the lesions are disseminated, on the arms and more especially the legs, they are closely aggregated. The lesions consist of varying sized papules, on the face, small, moderately hard, on somewhat inflammatory base; on the legs are dry hard papules around the hair follicles brownish in color, and capped with a horny plug. Some of these plugs project about one half of an inch above the surface. The younger lesions are covered with a brownish scale. Examined with a lens broken hairs can be seen.

Trichophytosis Corporis with Concentric Rings. Presented by DR. W. S. GOTTHEIL.

Boy, aged 8, has had a typical ringworm of the body for nine weeks, extending from just above the wrist to the middle of the right forearm. It is about three inches in diameter. It is peculiar in that there are at least three concentric rings of advancing fungous growth; an outer narrow margin of papulo-vesicles, then a small area of normal skin, then another ring similar to the first one, and finally a central mass occupying the largest part of the affected area. The arrangement is unusual, since as a rule the central and first affected area of ringworm of this variety is either clear of marked evidences of active fungous growth, or the entire affected skin is filled up with it.

Generalized Lichen Planus and Pityriasis Rosea. Presented by DR. W. S. GOTTHEIL.

Blanche B., Russian, in United States 12 months, has had her present eruption for three months; complains very little of it but seeks relief on account of the redness of her cheeks which is natural to many Europeans, though rather unusual in this country, and has no relation to her eruption. This appears to be general, but is most marked on chest and back, and with few lesions on the extremities. Many of the trunk lesions look like pityriasis rosea; large patches with faded yellowish centres, slightly scaly, and with distinct pinkish margins. Close examination with a lens reveals that many of these patches are distinctly

made up of groups of typical lichen papules, and others have the characteristic scalyiness of pityriasis rosea.

Three Cases of Papulo-Necrotic Tuberculides. Presented by DR. KINGSBURY.

CASE 1: M. P., female, twenty years of age. Born in Ireland but has lived in this country for the past five years. She is employed as a stenographer and her environment from a hygienic standpoint is a desirable one. No family or personal history suggesting tuberculous disease. Patient states that her health has always been good except for an attack of typhoid fever seven months ago. Shortly after her recovery from this disease she noticed that there were small pimples behind her ears. These soon broke down, leaving superficial scars. Somewhat later similar lesions appeared on the forearms and legs. These also ulcerated and left scars. This condition lasted about two years, and then the patient remained practically free of the eruption for about one year. The beginning of this improvement was coincident with her arrival in this country. Four years ago, however, the eruption reappeared on the forearms and legs, and although at times improvement is noted, she has never been entirely free from active lesions. Patient is well nourished but is rather anaemic. She has auburn hair and blue eyes. Physical examination of the chest was negative and there were no enlarged glands. At present typical lesions in all stages are found on the forearms, hands and legs. There are several hard nodules on the forehead and a number of inflamed papules behind the ears. A nodule was excised from the forearm and a piece of the tissue implanted subcutaneously in a guinea-pig. After nine weeks an autopsy was performed, but it did not reveal any evidence of tuberculosis. No giant or epithelioid cells were found in micro-sections made from same specimen.

CASE. 2: L. M., thirty-five years of age, widow. Born in the United States. She is well nourished and states that she has always had good general health. No tuberculosis history. Physical examination of chest was negative. No glands palpable. She has hair of a light brown color and grey eyes. The eruption has been present for the past five years. It is confined to the forearms and hands. There are only a few active lesions at present, but the forearms are studded with circular cicatrices. These average about one quarter of an inch in diameter. Most of them are white, although a few are slightly pigmented. Several hard papules are found on the extensor surfaces and a few of them show slight umbilication and beginning necrosis. There are a large number of small hard papules on the back of the hands. Only a few are umbilicated, and there is very little scarring on the hands. There are now some inflamed and ulcerated lesions on the middle and ring finger of the left hand. Patient states that sores on the fingers have at times been quite painful but that otherwise the disease has caused her but little discomfort.

CASE 3: H. H., female, single. She was born in the United States, and is now twenty years of age. Well developed and apparently in good general health. She has light brown hair and blue eyes. No tubercular family history. Physical examination showed the lungs to be normal and none of the superficial glands were enlarged. Patient has been troubled with the eruption for the past three years and believes that she had a similar condition when quite young. Lesions are now present on the arms, forearms, and legs. One very characteristic lesion is found near the center of a vaccination cicatrix on the left arm. The majority of the new lesions are about the size of a split pea. They begin as small papules and gradually develop into hard nodules of a purplish color. After a while they show evidence of central necrosis and are covered by an adherent crust. This is often removed by scratching, leaving a depression at the center. Finally this is replaced by a white scar. Several of the lesions were excised from the forearm, and numerous micro-sections were stained for tubercle bacilli, but with the usual negative result.

Epithelioma Nasi at the Age of Twenty-seven, Simulating Gumma.

Presented by DR. GOTTHEIL.

John F., aged 28 years, ambulance driver at Lebanon Hospital; sleeps over the stable at the hospital during the 13 months of his employment there. Denies syphilis, and shows no signs. One year ago a pimple appeared at the left side of the columella nasi, which he "picked," and which increased in size. No treatment for the first four months save peroxide washings. He then came to the hospital dispensary for treatment. There was then an elevated exulcerated mass occupying the entire surface of the septum on its left side, extending to the columella in front, and for half an inch upwards and inwards. Edges not hard or pearly; base crusted; diagnosis, Exulcerated Gumma. During the succeeding months he received energetic treatment, including 24 mercury salicylate injections, and the iodide up to nearly 600 drops of the saturated solution daily. There was no immediate result from treatment; but after a time the ulceration cleaned up, the crusts disappeared, the size of the lesion decreased. During the last few weeks, however, the process has remained stationary; and a slightly waxy indurated border has appeared at the lower margin of the lesion. Tuberculosis can be excluded, I think, on account of the margin and the absence of tubercular foci in the lesion or around it. I am inclined, therefore, in spite of the patient's age, to favor the diagnosis of epithelioma. As regards treatment, I consider both the knife and cauterizing agents inapplicable here, as certain to cause very great mutilation. I shall use the ray, though I am not a believer in its permanent curative action in these cases.

M. B. PAROUNAGIAN, M. D., *Secretary.*

REVIEW
of
DERMATOLOGY AND SYPHILIS

Under the charge of A. D. MEWBORN, M. D.

DISEASES OF SWEAT AND SEBACEOUS GLANDS

BY HERMANN G. KLOTZ, M. D., New York.

Acne Aggregata seu Conglobata. KARL REITMANN. *Arch. f. Derm.* XC, 249, April, 1908.

Under this name a type of disease is described which has much in common with acne vulgaris, but differs in some important points. In both diseases there are present: some seborrhœa, the copious appearance of comedoes, the presence of typical nodules; *i. e.*, there is present a process in which the sebaceous glands and the connective tissue surrounding the same, furnish the origin and the principal seat of the pathological changes. But acne aggregata does not begin until some time after puberty and has been observed only in men; it is accompanied by a considerable laxity of the skin and is localized on the entire trunk, face, extremities and genitals. Characteristic is the appearance of very large comedoes and of the so-called comedo-scars (Lang), the nearly universal presence of small comedoes in almost every follicle of the entire trunk as far as the scalp, the follicular and perifollicular inflammatory infiltrations which are largely confluent and, when softened, open on several places, the laxity and the brownish color which suggest tuberculous processes, and the typical exitus in characteristic depressed scars, also the frequency of the double comedoes. The histories of four cases illustrate the condition which does not seem to be uncommon in the clinic of Riehl.

Hidrocystoma Tuberosum Multiplex. WILHELM STOCKMANN. *Arch. f. Derm.*, XCII, 145, October, 1908.

Stockmann reports the results of the examination of three cases of that disease, which was first described by Kaposi under the name of lymphangioma tuberosum multiplex; and which M. Joseph has named Hydrocystoma tuberosum multiplex. Stockmann goes over the literature of the disease and comes to the conclusion that we have to do with tumors which may be designated as tardive nævi and which originate from abnormally placed sweat glands.

These abnormally located glands are arrested as early as the embryonic stage by forming compact strings of cells, which grow from the epidermis into the cutis. In the upper and middle portions of the stratum reticulare cutis they branch out in different directions, and by cell proliferation cell nests are formed in some places, which gradually are transformed in cysts, partly by degeneration of the central cells, partly by the retention of the secretion from secreting gland cells which have developed; or the cysts may be formed by the simultaneous action of both these processes. Through the further development and growth of the cysts the connecting cell cords dwindle and soon no further con-

nection can be recognized, neither between the cysts nor with the epidermis. Now the cell ducts appear only in the shape of short offshoots developing from the cysts and occasionally as elongated interpapillary plugs.

Other abnormally placed sweat glands may develop sufficiently to form coils of normal appearance and secretion. But from the duct which has a lumen, and in general does not differ much from the normal, by budding and cell proliferation cell strings develop, which grow into the surroundings. They mostly occur in the middle portion of the corium, but they may also originate from the base of the sweat gland duct. Such strings behave exactly like those which originate from the sweat gland formations, which were arrested in the embryonal stage.

Since the tumor consists of cysts which apparently at least in the majority are formed by the stagnation of secretion produced in the cells of sweat glands, the name hidrocystoma seems justified, while tuberosum multiplex may be retained in the name as a clinical feature and for the differentiation from other hidrocystomas.

Sebaceous Gland Hyperplasia and Epithelioma. G. A. GAVAZZENI.

Arch. f. Derm. XCII, 323, October, 1908

A tumor on the forehead of an elderly man, which had grown slowly at first, but later on quite rapidly, by the microscopical examination was shown to present normal sebaceous glands and in some places a basal-cell epithelioma. It was equally impossible to demonstrate a connection between the tumor masses and the sebaceous glands and the surface epithelium. The author considers at length the question, how the combination of the epithelioma and the large and numerous sebaceous glands could be explained; he concludes that the epithelioma originated on the basis of a senile hypertrophy of the sebaceous glands or of a senile sebaceous gland nevus.

Perifolliculitis Agminata Suppurativa, Saurefeste Bazillen in zwei Fallen von. KARL PREIS. *Arch. f. Derm.* XCII, 205. October, 1908.

In two cases of perifolliculitis agminata (Acnitis) in the pus enormous numbers of acid- and alcohol-fast bacilli were found, but not in the foci of the perifollicular inflammation, but in the follicles themselves which were dilated into cysts and formed real hollow ducts.

Inoculation and culture-tests were negative. It is not unlikely that these bacilli which preserved their acidfast qualities to a certain extent in celloidin sections, will be found yet in many cases of perifolliculitis agminata suppurativa. It must be left to further investigations to decide whether they have any etiologic connection with that skin disease.

Acidfast bacilli may also obtain access to the pus in torpid scrofula from neighboring bridges and niches and be mistaken for tubercle bacilli.

BOOK REVIEWS

INTESTINAL AUTO-INTOXICATION.

By A. Combe, M. D., Professor of Clinical Pediatrics at the University of Lausanne; Chief of Clinic for Children's Diseases; President of the Swiss Pediatric Society. Together with an appendix on the lactic ferments with particular reference to their application in intestinal therapeutics; by Albert Fournier, Former Demonstrator at la Sorbonne, Paris. Only authorized English adaptation by William Gaynor States, M. D., Clinical Assistant Rectal and Intestinal Diseases, New York Polyclinic; Member of American Medical Association; Member of State and County Society of New York; West Side Clinical Society, etc. With eighteen figures in the text, four of which are colored. Rebman Company, New York.

The author of this admirable work is not a dermatologist so he has refrained from entering into an extensive discussion regarding the relationship existing between intestinal autointoxication and the cutaneous diseases, but the book is rich in useful and valuable knowledge and should be found exceedingly interesting and instructive, especially to the dermatologist who desires to possess a broad knowledge of the subject. A careful perusal of its pages will convince the reader that intestinal autointoxication should be given very careful consideration in the etiology and course, not only of general diseases, but also of the disorders of the skin. The book cannot be said to be as exhaustive bacteriologically as, for instance, that of Herter, nor does the author devote as much attention to the saccharolytic type of intestinal trouble, but from a clinical standpoint the work is more complete than any we have so far seen. The difficult task of translation has been accomplished in a masterful manner and the English equivalents have been particularly well chosen.

The work opens with a consideration of the toxic bodies produced in the intestines, which is followed by a delightful description of the antitoxic functions of the organism. Then comes the etiology, pathogeny and symptomatology. The chapters on the latter subject, a very difficult one to handle, are well done indeed. The question of diagnosis is then considered and the author closes by devoting 213 pages to treatment. This part of the book is especially useful to the clinician for it deals with about every conceivable therapeutic measure, including the lactic and metallic ferments, the so-called intestinal disinfectants, hygiene, diet, lavage, hydrotherapy, etc. Unlike most foreign works, the book is well indexed; it is also well bound and printed in plain type on good paper. Many will undoubtedly offer the objection that the author is carried away with his subject, that he is too enthusiastic and that he takes too much for granted, but most of his assertions are supported by extensive clinical and bacteriological experiments both by himself and others. Students of this subject should not be too hasty in criticising the facts as presented. They must be negated not by theoretical deductions, but by actual and extensive physiological and clinical experimentation. So far, at least, the majority of investigators are in fair accord with the opinions as advanced by the author.

G. M. M.

LEHRBUCH DER HAUT—UND GESCHLECHTSKRANKHEITEN, FÜR STUDIERENDE UND PRAKTIISCHE AERZTE. ZWEITER THEILS DIE GESCHLECHTSKRANKHEITEN von *Ernst Finger*. Mit 8 lithographischen Tafeln. Sechste, wesentlich vermehrte und verbesserte Auflage der "Syphilis und Venerische Krankheiten." *Leipzig und Wien. Franz Deuticke. 1908.*

As the title explains, this is not really a new book, but a new edition of an older one, the last, the 5th edition of which had appeared in 1901. The author states that he delayed the publishing of this new edition because he considered it absolutely necessary to wait the results of the new discoveries of the possibility of the inoculation of syphilis in monkeys and of the *spirochaeta pallida* as the cause of syphilis. This book now presents the attempt to re-build and reconstruct the entire chapter of syphilis upon the new etiological basis. The new experimental, bacteriologic-etologic and sero-diagnostic investigations, the author says, have done away with much that was old and hypothetical and have created new and securely founded knowledge. It may well be questioned whether the time has really been reached for such an undertaking and whether sufficient facts have been established by this time to warrant an entire reconstruction of our empirical doctrine.

On the strength of the demonstration of the *spirochaeta pallida* in tertiary lesions the infectiousness of the same has theoretically to be admitted, but practically under the ordinary conditions of life they must be considered non-infectious to the healthy and hardly dangerous (page 15). Regarding the physiological secretions, the infectiousness of milk is not beyond doubt; as to the urine the demonstration of *spirochaetae* in the urine of patients suffering from secondary syphilitic nephritis seems to prove the possibility of infection. Saliva is not mentioned, but owing to the successful inoculation of two monkeys with sperma it must be admitted that sperma may carry infection.

Greatly changed is the conception of immunity: recent investigations seem to demonstrate that the skin of the syphilitic does not possess absolute immunity during the stage of activity and possible relapses (p. 21), but reacts identically on its own and on extraneous virus. Immunity begins to develop as early as the period of the primary affection and gradually increases in intensity during the secondary stage, but it does become absolute only at the moment when syphilis ceases to relapse. Hereafter it again begins to diminish with more or less rapidity so that re-infection may occur, but extraneous virus as well as that remaining in the organism now produces changes of the gumma type. The gumma has to be considered as the outgrowth of the virus within a transmuted organism ("umgestimmt," tuned to a different pitch), an organism which, because still immune, does not allow an abundant proliferation of the virus, but in which is produced an oversensitiveness and an exaggerated reaction towards the scanty virus and its products. After the patient has passed through the tertiary stage or has escaped it entirely the immunity further decreases and the organism's susceptibility to the virus of syphilis gets nearer and nearer to that of the healthy one.

The demonstration of the *sp. pallida* in the majority of the syphilitic skin lesions renders it without doubt that every single lesion presents the local relation to a localized focus of reproduction of the syphilitic virus. But it seems that the first eruption has a different origin from the later, relapsing syphilitic exanthemata. While the former are produced by the hematogenic way, due to embolic deposits of the virus, this origin is not considered common for the later lesions, although not entirely denied; their occurrence is rather explained by deposits of the virus which remain from the first eruption on certain localities, in a state of latency at first, but later on called into activity again by causes unknown at present. These residual foci seem to persist particularly in the periphery of the original lesions and give rise to the frequently observed annular arrangement of the later syphilides. This explanation would appear more prob-

able if the first eruptions were always as widely distributed over the body as described in the book, instead of frequently appearing in quite scanty numbers and in restricted areas, and if the later eruptions did not often show a predilection for some localities like the palms and soles, the scrotum and anal fold, the face and other places which are by no means regularly included in the first eruption. To proclaim such dogmas seems rather premature, particularly in the face of the paucity of actual facts revealed regarding the life history of the *spirochaeta pallida*.

The differential diagnosis (p. 88) of pityriasis rosea is by no means always as simple as stated here, the itching mentioned as characteristic of this disease, is far from constantly present. Erythema multiforme and nodosum syphiliticum (p. 78) are given due consideration. Balanitis, urethritis and vaginitis are mentioned as dangerous sources of infection (p. 82). The relapsing papular syphilide of the palms and soles (p. 92) is well described, but it is not mentioned that it may appear at a very late period. Leucoderma (p. 100) always develops from a macular lesion and the transposition of the pigment occupies the seat of the former, but where a papular lesion is the starting point an annular zone of pigmentless skin appears around the single lesion which, narrow in the beginning, later on spreads, while in the center the brownish-red pigmentation remains as the effect of the papule. In the chapter on hereditary syphilis (p. 208) the conditions of germinative and postconceptional infection are carefully considered in the light of the new investigations which have shown some quite unexpected results.

Coming to therapeutics, Finger is an adherent of the chronic intermittent treatment (p. 259); the manifestations of the primary stage, as a rule, are treated locally, except under certain complicating conditions general treatment is not commenced until the manifestations of general syphilis, the so-called secondary symptoms, have become fully developed. It is greatly to be commended that the author has resisted the temptation to relinquish this old rule on account of the new discoveries, while so many writers, particularly in this country, have hastily abandoned the old method. Finger acknowledges that some efforts, to prevent by all means the general infection of the patient, that is by the excision of the primary lesion followed immediately by some energetic general mercurial treatment, have been given encouraging results. However, this question, he says, is still in the stage of an experiment, and perhaps, on account of the individual variations in the course of the disease, will not give results which can be applied to all cases.

The second part of the book is devoted to the venereal ulcer. Blennorrhœa is the subject of the third part in which are comprised the gonorrhœa in men with its complications, and gonorrhœa in the female also with local complications; then follow those complications which are common to both sexes: rheumatism, angioneurotic exanthemata, blennorrhœa conjunctivæ, iritis gonorrhœica and rectal gonorrhœa. The author's views on these subjects are well known from his book on blennorrhœa of the Sexual Organs. In a final fourth part we find some diseases of the sexual organs which occur either idiopathic or as complications of venereal diseases, namely: balanitis, vulvitis, condylomata acuminata, phimosis, paraphimosis, lymphangitis and adenitis. It would have been appropriate to add to this class of diseases a chapter on herpes progenitalis, an affection much neglected in textbooks and frequent source of mistakes and errors.

The eight beautifully executed plates illustrate the pathological conditions and the bacteriology incidental to the venereal diseases, particularly the *spirochaeta pallida*. For the illustration of the gonococcus Pappenheim's methylene-green pyronin stain has been used.

H. G. K.



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